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Passim.

CHRISTMAS has come and gone and we, albeit a little late, hasten to offer to all our readers a happy and prosperous New Year. This Christmas has not, of course, differed in its essentials from that of other years. It has been just as exciting, just as tiring, just as merry, and just as bad for us as in previous years, but we have all nevertheless entered into it with as much zest as ever. New generations of students and nurses have decorated and flirted; fresh patients have made old-fashioned paper flowers; a fresh batch of children have been so petted that their mothers will, we think, have their doubts about the value to their children of a Christmas in hospital. In fact, everything has been exactly as before; the actors may change but the play goes on. Our life here is a microcosm of the greater world beyond Maze Pond, and as in that world, so with us the essentials of our life vary but little from year to year.

THE Wards were gaily decorated with ivy and flowers, the prevailing colour of the lamp shades being, of course, red or pink, although one or two daring innovators used green or white. There was, we thought, a tendency to revert to the more elaborate schemes of decoration which were so popular four or five years ago. The Colonnade was gay with multi-coloured posters announcing the Ward Concerts. It is a curious fact that most of our poster artists are more diffident than their professional brethren, and but rarely sign their names at the foot of their productions. They need not be shy, most of the posters are very good indeed.

THE Niggers were excellent, and were, of course, greatly appreciated, especially by those privileged children who were actually allowed to shake hands with the mysterious strangers. If we may make one little criticism it is to the effect that the troupe was a little too small. What they lack in artistic skill the Niggers should make up in noise. It was a graceful thought to use again this year, on the programme, the drawings made for it last year by R. M. Wingent.

THE Landon Christmas Tea was as successful and as noisy as ever. Only those who have spent an afternoon at the Tea can appreciate how great that success is and, still more, how ear-splitting that noise is. Still, the sight of those 700 happy little faces, smeared with jam, and grinning from ear to ear in the intervals between screaming out one of the latest, or oldest, pantomime songs, is sufficient compensation for all the hard work that was necessary as a preliminary, and we are sure that Sister Out-Patients and all her helpers are more than satisfied. As usual, the children went home laden with toys and more useful presents in the shape of stockings and mufflers.

As in previous years, the Tea was greatly assisted by gifts from generous donors, and as usual also the men, and more particularly the

Dental men, were only too keen to help both by their subscriptions and in other ways. To all those who helped to make even so small a number of Borough Children happy for one afternoon, we offer Sister Out-patients' grateful thanks.

THERE was much curiosity in the Colonnade on Monday last when a motor-'bus drove up to the front of the Hospital and was quickly filled by between forty and fifty smiling "kiddies." Some urgent questioning elicited the information that it was a little expedition arranged by an O.P.O. and a Clinical to see the Pantomime at the Elephant and Castle Theatre. The idea was a very happy one, and we congratulate the gentlemen concerned. We are sure that the delight of their guests was more than sufficient acknowledgment for their trouble and expense.

OUR dramatic critic has referred elsewhere in our columns to the excellence of Mr. Stanley Cock's drawing entitled "Frankie as Nijinski" which appeared on the cover of the Programme of the Residents' Theatricals. We are very pleased to learn that copies of this sketch, signed and mounted in a manner suitable for framing, will very shortly be available for purchase at 2s. 6d. each. They may be obtained from Gray at the Porter's Lodge in the College.

THE Standing Orders for the various Appointments now open to Dental Students have been bound together in pamphlet form for their convenience, and copies of them may be obtained on application at the Medical School Office. All those men who have not yet possessed themselves of a copy are advised to do so at once.

WE publish with great pleasure in this issue a letter from Drs. H. C. Mann and P. S. Price on the subject of the proposed memorial to the late R. M. Wingent. We are in the very fullest sympathy with the subject of the letter and wish to do all in our power to help it forward. Apart from our own personal sorrow at the death of so true and sincere a friend as Wingent we have to lament on behalf of the GAZETTE a very tower of strength whose articles and sketches have been one of the chief attractions of recent years. We know well that it has only to become known among his friends that a memorial is being raised to ensure their hearty co-operation.

The suggestion which at present finds most favour is that for a permanent memorial to be placed in the Gazette Museum of Antiquities. This spot seems particularly appropriate, since the Museum of Antiquities owes its origin to Wingent's love of the Hospital and its past, and was organised by him during the last year. He was its first Curator, and it is already known here in the Hospital as Wingent's Museum. Subscriptions should be sent either to Dr. Mann or Dr. Price, or to the Editor of the GAZETTE, who will forward them to the proper source.

THE Guy's Hospital London University Club will hold its Annual Dinner early in February. On the occasion of the last dinner of this Club we drew attention to the very poor attendance of members, and discussed the reasons why the dinner was not as successful as might be expected. The whole matter has recently been discussed by the Committee, and various remedies were suggested. Finally it was agreed the price of the dinner should be very materially lowered to four or five shillings a head, and that every effort be made to stir up London University men to attend in February. We are convinced that if there was a good turn up of men in the wards and dissecting-room, the success of the Club would be assured.

THE present issue of the GAZETTE opens a new volume, the twenty-eighth. An index and title pages for last year's volume will shortly be prepared, and readers who wish to have their sets bound should send them to the Librarian. The bindings are in two shades of blue, with the Hospital Arms in gold. We would also remind our readers that subscriptions for the year 1914 are now due and should be sent to the Manager of the GAZETTE.

G. T. M.

Laryngeal Paralyses.

CLINICAL LECTURE BY T. B. LAYTON, M.S.

GENTLEMEN,—There are two vocal cords; we have, therefore, to discuss unilateral and bilateral paralyses. These cords move inwards on adduction and outwards on abduction; we have, therefore, to consider adductor paralysis, abductor paralysis, and complete paralysis. Again all paralyses are divided into those due to functional and those due to organic disease, and these last are subdivided into lesions of the upper neurone and lesions of the lower neurone. As I told you in my demonstration last week, the upper neurone mechanism of the larynx is strictly bilateral; to obtain, therefore, an upper neurone organic lesion we must imagine two exactly symmetrical lesions of the cortex, corona radiata or internal capsule. It is doubtful whether such lesions have ever occurred, and so we may put organic upper neurone lesions out of our consideration. The possible combinations may be further narrowed, for in 1880 Sir Felix Semon[1] laid down a law, which has since born his name, that in all organic lower neurone lesions of the larynx, whether unilateral or bilateral from whatever cause, the abductor fibres are first involved and often are the only ones involved, and as a corollary to this that functional paralyses of the larynx which are always bilateral involve the adductor muscles only. The opposite of these two statements are also true, that paralyses of the abductor muscles or complete paralyses are always organic in origin, and that paralyses of the adductors only are always functional. During the three and thirty years which have elapsed since that time one case only has been recorded which is contrary to this law.

This is a case carefully recorded by Saundby and Hewetson[2] of carcinoma of the œsophagus, in which abduction had consistently been observed for six weeks before death, though adduction had been impossible; the width of opening had diminished slightly during the last week or so. Diagrams of the condition were made on more than one occasion during life. Post-mortem, both vagi with their recurrent branches were found passing through masses of growth in the glands of the neck; the right was more involved than the left. On microscopic section the nerve trunks were found to be invaded by growth, and beyond the the place where the recurrents left the growth to enter within the pharyngeal wall they showed degeneration by certain of their fibres being devoid of axis cylinders. The muscles were also examined microscopically and were found degenerate, those on the right side being more involved than those on the left. The thyro-arytenoids were most degenerate, next to these the lateral crico-arytenoids and the arytenoideus, while the posterior crico-arytenoid muscles were involved to a lesser degree. This last observation fits in with the lessening of abduction observed shortly before death.

The conditions which we must consider may therefore be classified thus—

i. Organic bilateral abductor paralysis.
ii. Organic bilateral complete paralysis.
iii. Organic unilateral abductor paralysis.
iv. Organic unilateral complete paralysis; these two may involve the left or right side of the larynx.
v. Functional bilateral adductor paralysis.

Our diagnosis of these conditions consists of two stages—

I. To make a correct estimation of the condition of the larynx.
II. If there is a paralysis of the muscles moving the crico-arytenoid articulation, to find out the cause of this paralysis.

I. From my own experience, and from that of those who have worked under me, I have found that the hardest part of the laryngeal examination is the estimation of the movements of the cords. I do not intend to give you a detailed description of how to examine a larynx, that can only be taught practically in the out-patient department, but I would give you two double hints which I think may be useful. First, if the patient will hold his tongue himself let him do so, this will give you a free hand to place lightly upon the head of the patient, which you can turn to the right or left, upwards or downwards, as you need, with the slightest touch. If, however, he will not *hold it* himself, take care that you only *hold* the tongue which the patient himself protudes, and do not *pull on* it. Secondly, if you can examine the patient without attracting his attention to his respiration it is better to do so; the glottis then lies in the position of quiet respiration between the cadaveric position and that of deep inspiration; if, however, the patient retches and is intolerant of examination, tell him to breathe in and out panting slightly, there are then slight respiratory movements of the cords, outwards on inspiration and inwards on expiration. Having examined the larynx in the resting position, the patient must now phonate in order that one

[1] Archives of Laryngology, vol. II., No. 3, reprinted with some alterations in Forschungen und Erfahrungen (1880–1910), vol. I., p. 3.

[2] B.M.J., 12th March, 1904.

may examine the condition of the adductors, and must take a deep breath for the examination of the condition of the abductors.

As in other parts of the body paralyses must be distinguished from other conditions limiting movements of a joint.[3] In the larynx, fixation of the crico-arytenoid joint and infiltration of the vocal cords by inflammatory tissue are the conditions to be excluded. We have recently had cases which exemplify each of these conditions.

CASE 1 is that of a woman, æt. 34, who came to the throat department for ulceration of the pharyngeal wall. On examination of the larynx the left cord was seen not to move at all; the corresponding arytenoid process reached higher up than did the other, and on phonation the right process came up to and hid itself under the left process, *but did not move it at all.*

She gives a history that this came on twenty years ago after scarlet fever, and has been observed subsequently by several laryngologists.

The immobility is the main diagnostic point, for in cases of paralysis the healthy side on phonation may actually push the paralysed side outwards, whereas if the joint be fixed the process on the diseased side will not budge. It is clear that such a diagnostic point is often hard to determine, aud the diagnosis is further complicated by the fact that owing to want of movement a paralysed cord becomes ultimately fixed as well; and, therefore, much difference of opinion is often found even among experts in these cases. There is a case in point at present attending my out-patients.

CASE 2 is a woman who has attended first Dr. Shaw's and then Dr. Fawcett's out-patients since 1895 for exophthalmic goitre; she has a slight huskiness of the voice due to an immobile left vocal cord, which on examination seems to me to be due to a fixed-joint.

The golden rule which demands that all lesions should, if possible, be explained by one pathology makes one wish to call this a paralysis due to pressure on the nerve by the enlarged thyroid. The probable explanation is that it originally was a paralysed cord which has subsequently become fixed.

My next case is one which exemplifies the difficulty of telling cords fixed by inflammatory exudation from paralyses.

CASE 3[4] was a man, æt 40, who came to the Out-Patient Department suffering from dyspnœa of a fortnight's duration. On examination he appeared at first to have considerable narrowing of the glottis, due to bilateral abductor paralysis. More careful examination showed, however, that this was really a bilateral sub-glottic swelling, and that the true cords lay over the upper end of the swelling. The diagnosis was clinched by the movements of the glottis, for on inspiration the front part opposite the cords became narrower, while the back part opposite the cartilages widened. This means that the arytenoid cartilages were moving freely over the cricoid, and that there was no paralysis, while the sub-glottic swelling was sucked into the lumen of the larynx as the pressure below was diminished.

In addition to diagnosing paralysed cords from fixed cords they must also be diagnosed from normal larynges.

In the slighter degrees of paralysis the bilateral condition is more difficult to determine than the unilateral. The reason of this is that the normal with which the degree of abduction must be compared is the mental picture of a normal larynx in the mind of the observer, whereas in a unilateral paralysis the normal side lies opposite with which to compare the paralysed side.

CASE 4 is that of a man, æt. 64, on whom Sir Arbuthnot Lane performed a gastrostomy in July for dysphagia due to a carcinoma of the hypopharynx. I was asked to see him by Dr. Iredell with a view to considering how diathermy might be applied directly to the growth. I noticed that he had a slight hoarseness, and on examining the larynx I found that the cords did not abduct beyond the position of quiet respiration. From the position of phonation to that of quiet respiration the movement was free, but on taking a deep breath the glottis opened no further. This case showed a physical sign mentioned in the books, for on taking a deep inspiration there was a slight momentary adduction of the cords instead of the normal abduction. He had, therefore, an abductor paresis of both sides of the larynx. A week later he died. Post-mortem, a growth extended from the arytenoid processes to the level of the aortic arch. The recurrent laryngeal nerves entered secondary deposits around the œsophagus.[5]

While it may be hard to determine the presence of an abductor paresis, it is on the other hand possible to mistake a normal larynx for a unilateral paralysis.

CASE 5.—While working in the clinic of Professor Killian last July twelvemonth I saw a patient in whom I diagnosed a right abductor paralysis. The Professor was very delighted at the joke when he told me it was a normal larynx.

During the past year one of my dressers has made an exactly similar mistake. The mistake is due to the laryngeal mirror being held sideways so that the image of the glottis is not

[3] First emphasized by Sir Felix Semon in the *Medical Times* and *Gazette*, 1880.

[4] This case was not mentioned when the lecture was delivered, being seen first on the subsequent out-patient day.

[5] The diagnosis has since been clinched by the fact that the abductor paralysis has since become complete, necessitating a tracheotomy.

median, but one cord appears to lie in the mid-line of the mirror while the other lies far out apparently abducted. This mistake can be guarded against by examining again with the mirror in the other hand, when the reverse condition will be seen.

II. Having determined that there is a paralysis we must now consider the diagnosis of its cause. In the beginning of my lecture I shewed you how we could narrow down our considerations to organic and functional. The complete organic paralyses are very rare conditions, for they are the later stages of the incomplete ones and as these are almost all of serious prognosis many cases never pass on to the complete stage. Indeed, the importance of the subject is one of diagnosis and prognosis rather than of treatment. We shall find that nearly all cases are due to some serious condition, and treatment is directed to the primary lesion rather than to the paralysis. It is a serious thing, therefore, to diagnose a paralysis of the larynx in a normal person, or to pass off as a trivial disorder some slight hoarseness or cough in a person in whom a paralysis is present.

We must consider then the bilateral and unilateral conditions.

A. Bilateral paralysis.—The diagnosis here depends upon excluding a gross lesion which can press upon both recurrent laryngeal nerves or both vagi. If no such lesion is present the cause must be a central one in the medulla.

I have already mentioned (in Case IV.) a patient in whom a growth of the hypopharynx has involved both recurrent nerves. These enter underneath the insertion of the inferior constrictor muscle of the pharynx, and lie in the submucous tissue over the posterior crico-arytenoids just behind the crico-arytenoid articulations. Such a case is distinctly rare, one nerve or the other is not infrequently picked out by a growth of the œsophagus, but that both nerves should be involved the growth must lie on the anterior wall of the hypopharynx where this joins the œsophagus.[6]

I have already indicated (in Case II.) the possibility of a thyroid enlargement involving one nerve. So also a bilateral enlargement of this gland may involve both of them.

CASE 6.—I remember Mr. Symonds's demonstration of a case of complete bilateral paralysis on one of his teaching afternoons; it is the only case of the condition that I have seen, and the poor man was suffering from advanced malignant disease of his thyroid gland.

Other possible cases are those where aneurysms of aorta and right subclavian co-exist, where enlarged glands press upon both vagi, or where a pachymeningitis involving the posterior fossa pricks off both jugular foramina. These conditions must, however, be extremely rare, and if none such are found, we may infer that the cause lies in the medulla.

Such cases come under two heads, those where other muscles are involved, and those where the larynx only is involved. The former are those which are described in the books as labio-glosso-laryngo-pharyngeal paralysis. They come up rather to the physician or neurologist than the laryngologist, and I do not remember ever to have seen one. Of the other cases the great majority of them are due to locomotor ataxia. There may be no other symptom of the disease, or some support to the diagnosis may be got by careful examination. Of the latter class a case which came up to the throat department several years ago when I was clinical assistant to Mr. Steward is an example.

CASE 7 was a middle-aged man with attacks of dyspnœa due to bilateral abductor paralysis. He had no ataxia, the eyes were normal, the knee-jerks were present; but on testing the tendo-Achilles jerks they could not be obtained.

The former class is exemplified by a case recently in Clinical under Dr. Hale White.

CASE 8 is that of a man who had complained of dyspnœa for three weeks; it had steadily progressed and was now sufficient to cause him some distress. On examination there was bilateral abductor paralysis with some associated laryngitis. A tracheotomy was performed under novocaine, and he was fitted with a tube which has a plug in it that he can remove if dyspnœa again becomes urgent. No other symptoms of locomotor ataxia were found, but he acknowledged having had syphilis, for which he had had but two months' treatment with medicine, and the complement fixation test was positive. He was given salvarsan and put on a course of mercurial injections. At the end of two months the larynx was practically normal.[7]

[6] The subsequent history of Case IV. proves this statement to be incorrect; see Note 5, above.

[7] On the Friday after this lecture was delivered he was shown at the Laryngological Section of the Royal Society of Medicine. Here he was seen by Sir Felix Semon, who, in conversation with the author, said that he doubted whether it was ever a case of paralysis, so marked had been the improvement, and that he was suspicious that the case had all along been one of syphilitic laryngitis. Sir Felix Semon based his scepticism on the fact that he did not believe that the abductor fibres and muscles could possibly have recovered to such an extent in so short a time. He admitted that recent advances in the treatment of locomotor ataxia may entirely alter our views as to the prognosis of these paralyses, but said that in cases which he had known to recover, the actual return of function of the muscle was spread over a much greater period than in this case. This criticism tends to emphasize what I have said above as to the difficulty of diagnosis in these cases; let us hope that we shall never know whether the diagnosis was correct or not. It is satisfactory to think that had the diagnosis been otherwise we should have treated him in the same way; it makes, however, a very considerable difference to the prognosis.

In some cases, however, an exact diagnosis is almost impossible, as is seen by the following case.

CASE 9. Annie T., æt. 48, came up to Dr. French's out-patients complaining that she makes a whistling noise when asleep which disturbs people sleeping in the next room. She has some shortness of breath on exertion, but no difficulty when in bed or otherwise at rest. Running across the first left intercostal space is a scar where, as she says, an abscess burst which she treated herself, and which took a long time to heal. She is very definite that the whistling noises followed on the rupture of this abscess which occurred thirty years ago. Dr. Lindsay Locke examined her with the X-rays, and was able to demonstrate that the whole area around the apex of either lung was normally translucent, there was no evidence of old fibrosis around the lung or of pleural thickening. Examination of the blood and of the nervous system were each of them indefinite. Dr. Lucey reported that the blood gave a weak positive reaction with the complement fixation test. Dr. French says that the tendo-Achilles jerks are obtainable with difficulty on some examinations, and not at all on others. No other symptoms of nervous disease have been found. Dr. Eason reports that there are no fundus or other eye changes. Dr. French sent her to me for examination. There is bilateral abductor paralysis, the glottis not opening quite as far as the normal position of quiet breathing, the pharynx and palate move well, there is no facial paralysis; when asked to protrude her tongue she puts it out slightly to the right, but if asked to put it straight out she can do so normally.

We have here then, a case in which the difficulty of obtaining the tendo-Achilles jerks suggests the possibility of locomotor ataxia, and the abnormality of the tongue suggests the possibility of bulbar paralysis. The very definite history which she—an intelligent woman with short reaction period—gives makes one suspicious that it is neither of these. One hesitates to diagnose syphilis on a weak positive reaction in the absence of any other evidence to support it. Time, or a more extended examination of the nervous system may enable us to make a diagnosis, but in the meantime we must keep an open mind on it.

The treatment of these cases has been indicated in the description of Case 8. The patient may get a spasm of the larynx which will cause dyspnœa so urgent as to endanger his life. Therefore a tracheotomy should be done, and a tube worn either with a pea-valve or a plug, so that he can expire through the larynx, and on expiring phonate. The alternative is for him to wear an intubation tube, but then the voice becomes lost. In Case 9 the paralysis is not enough to necessitate a tracheotomy.

B. Unilateral paralysis.—I do not intend to give you a complete list[8] of the causes of these paralyses. The left side, for anatomical reasons, is more often involved than the right, and yet the disproportion is not so great, as I for one used to believe. Dr. de Haviland Hall[9] gives 82 cases on the left side and 33 on the right. The proportion of the latter is probably larger than it should be, as his figures are based partly on the cases shown at the Laryngological Society, where rare cases tend to be shown. Of these, aneurysm of the aorta accounted for twenty-eight cases on the left and three on the right side, and one was in a case of aneurysm of the right subclavian. Carcinoma of the œsophagus accounted for eight on the left and nine on the right side, while those combined with other paralyses accounted for four on the left and six on the right. I have already discussed the need to distinguish these cases from those of a fixed joint. These cases do not usually cause any laryngeal symptom sufficient for the patient to come up for that symptom. They are observed under three conditions:—(i.) in the routine examination of the larynx when a patient attends for some other nose or throat lesion; (ii.) when they are definitely looked for in the diagnosis of conditions which are known to cause them; and (iii.) when the observer notices some slight laryngeal symptom which makes him examine the larynx in order to discover or to exclude a grave lesion. On these last two I would say a few words. When an elderly man attends with a brassy cough[10] in whom no evidence of aneurysm can be found in the chest, he should not be sent away as having some trivial complaint without an examination of the larynx being made, for the earliest objective symptom of this may be a left abductor paralysis; for those of us who live with an X-ray expert at every corner it may be easier to have the chest examined by him, but in parts of the world where such an examination entails a long journey the laryngeal examination is one of extreme importance. In cases of dysphagia the presence of a left abductor paralysis is rather in favour of aneurysm, of a right paralysis distinctly in favour of carcinoma of the œsophagus, yet the symptom must not be relied upon, but must be considered with the other symptoms.

[8] One will be found in Sir St. Clair Thomson's book, p. 518.

[9] Proc. R.S.M. Laryngology Section, 1913, p. 140.

[10] On this point see the Lumleian Lectures by Dr. de Haviland Hall, published in the *Lancet*, 1913, vol. I.

The small laryngeal symptoms which may attract the observer's attention are a slight huskiness, and a slight noise on inspiration. The former once led me to make an entirely different prognosis in a case.

CASE 10.—In the summer of 1908, I was an assistant at the Poplar and Stepney Sick Asylum. A patient was sent in as having bronchitis, but as no abnormal physical signs could be found in the lungs I was at a loss to know why he was admitted. A huskiness in speaking led me to examine the larynx, and a left abductor paralysis was found; a further careful examination of the chest revealed no abnormal physical signs, but there was little doubt that he had some serious disease. A week later he was dead, and post-mortem, the whole posterior mediastinum was full of carcinomatous deposits apparently secondary, though no primary growth could be found.

Of the slight inspiratory noise I have already given an example in Case 2. This is the condition which occurs sometimes in race-horses when they are known as roarers.

When the paralysis is associated with paralyses of other cranial nerves, the diagnosis depends upon a discussion of anatomical probabilities within the skull.

Like the bilateral paralyses the unilateral ones are important chiefly from the diagnostic and prognostic point of view. There are some cases in which no cause can be found during life, but even though the cause cannot be found, it is almost certainly of grave importance, and we must consider as serious every case of abductor paralysis.

There remains the adductor paralyses; these as we have said are always functional. Except in name, they have nothing in common with the abductor, and complete paralysis. Their clinical aspect is an entirely different one, and it would be well to defer their discussion to another time.

[We regret that in Mr. Layton's Demonstration which we published in our last issue, and which was an introduction to this lecture, the figures were put over the wrong explanations. The figure after Kosaka was printed at the end over the page, this should have been No. 2. The brain of the bonnet monkey, after Semon and Horsley, is No. 3, the other two following in order. ED.—G.H.G.]

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

The late R. M. Wingent.

DEAR SIR,—We have reason to know that there are many Guy's men who wish some permanent memorial to the memory of Ralph Wingent in the Hospital. It has been suggested to us that this should be placed in the Museum of Antiquities in the annexe of the Wills Library, which is already spoken of among Hospital folk as "Wingent's museum."

To us, who have known him since he first entered as a student, who have valued his unselfish friendship and who have tried to live up to that standard of fellowship which he set among Hospital men, his brave patience, through eleven years of physical infirmity (eleven years spent in the knowledge of aortic disease), will speak and stimulate and live for always. But now that his eloquent and inspired pencil is still, we want, in common with many others, to honour him to whom honour is due and to leave to the coming generation of Guy's men a record of brave and patient endeavour which distinguished the life of one of our time, a man who never spoke ill of others, who knew not the petty jealousies which only too often hamper and shame the work of those who are members of a community such as ours.

We already hold the sum of thirty shillings which was collected among the Residents in College for the purchase of a wreath. The wreath was not obtained because his relatives desired that no flowers should be sent. At the request of the donors this sum will be transferred to the Ralph Wingent Memorial Fund, for which we have been asked to collect subscriptions. We propose to keep the Fund open until the end of June next so as to enable those of his many friends who are scattered abroad to send their contributions. We shall be prepared to receive any sums, large or small, and to acknowledge them in the columns of the GAZETTE.—Yours truly,

P. SEYMOUR PRICE,
57, Sloane Gardens, S.W.

H. C. MANN,
The College, Guy's Hospital, S.E.

Change of Address.

J. Moncrieff Joly, M.B., B.S., M.R.C.S., L.R.C.P., from 4, Emperor's Gate, S.W., to Bara Hapjan P.O., Upper Assam, India.

Dr. Alfred C. Jordan, from 11, Bentinck Street, Cavendish Square, to 13, Upper Wimpole Street, W.

Harry Lee, B.A., M.B., B.C. Cantab., F.R.C.S. Eng., from 49, Queen Anne Street, W., to 6, Park Square, Leeds.

The Residents' Theatricals, Christmas, 1913.

Another Christmas Play has come and gone, and, as usual, it is now the chief topic of discussion in Ward or College. We may say at once that the whole performance was an unqualified success from beginning to end. This is all the more praiseworthy since the entertainment was on an even more ambitious scale than in previous years. Encouraged by the successes of the two previous Christmas plays the authors determined to emulate the music-halls and produce a Revue. Their success is their justification.

The cast of the play was as follows:—

DROP THAT BRICK:

THE LAST WORD IN REVUES.

By T. I. B., H. W. B., and P. H. B.

Music by R. S., C. H. R., and T. I. B., the Lienteric Composers.

Additional Numbers stolen from the States.

Scene I.—The Colonnade.

A Porter	H. C. Rook.
Algernon Mugwash	P. D. Scott.
Percy Ffitzhardly	R. Sells.
A House Surgeon	W. J. D. Smyth.
A Sister	G. S. Miller.
A Probationer	H. L. James.
An American	R. C. Ozanne.

Chorus of Students, H. P.'s, Bathmen, and other Brainworkers.

Scene II.—Barabas Ward—six months later.

A Male Patient	G. Richards.
A Female Patient	A. B. Danby.
A New Patient	W. Robinson.
Camelia, a Ward-maid	T. I. Bennett.
A Sister	G. S. Miller.
A Probationer	H. L. James.
A Registrar	R. C. Ozanne.
Algernon Mugwash	P. D. Scott.
Percy Ffitzhardly	R. Sells.
A Porter	H. C. Rook.
Chorus of Students	J. L. Perceval.

Scene III.—An Operating Theatre—six months later.

A Probationer	H. L. James.
Percy Ffitzhardly	R. Sells.
A House Surgeon	W. J. D. Smyth.
A Patient	G. Richards.
A Sister	G. S. Miller.
A Surgeon	R. A. Fawcus.
1st American	E. L. Blake.
2nd American	J. L. Perceval.
Algernon Mugwash	P. D. Scott.

Chorus of Americans.

Scene IV.—An Island off the Coast of Africa—a month later.

Dr. Cuthbert Wrench	W. Robinson.
J. L. Perceval	J. L. Perceval.
Dr. John Corset	T. I. Bennett.
Kalar Azaar	H. C. Rook.
His Attendants	A. B. Danby, E. L. Blake, W. J. D. Smyth.
Sick Natives	R. A. Fawcus, H. L. James, R. C. Ozanne, G. Richards.
Algernon Mugwash	P. D. Scott.
Percy Ffitzhardly	R. Sells.

Scene V.—Out-Patients—18 months later.

A Nurse	H. L. James.
A Probationer	E. L. Blake.
Out-Patient Officers	T. I. Bennett and H. C. Rook.
An Old Lady	R. A. Fawcus.
Mr. Blaytan	R. C. Ozanne.
A Radiographer	W. Robinson.
An Enigma	J. L. Perceval.

And many of the Old Crowd.

The authors T. I. B., H. W. B., and P. H. B., are respectively T. I. Bennett, H. W. Barber, and P. H. Berry. The Lienteric Composers are R. Sherwood, C. H. Rook, and T. I. Bennett. We congratulate them all very heartily and thank them for providing us with a most delightful evening.

The opening scene was placed in the Colonnade, and introduced us at once to the *Porter* (Mr. Rook), who provided us with amusement throughout the rest of the evening. Shortly there arrive on the scene two new 'Varsity men, *Algernon Mugwash* (Mr. Scott) and *Percy Ffitzhardly* (Mr. Sells), who announce themselves as Sir William Lane's new ward clerks, and provide us with the *motif* running through all the scenes in their mutual determination to be Sir William's H.-S. one day. This pair, whose acting is extremely clever throughout, then treat us to a song, of which the chorus is as follows:—

Algy and Percy are two of the lightest sparks,
Each is the compleat
'Varsity graduate.
Now we're ward-clerks.
And when in the morning we write our reports
Every Nursie says "Mercy,
These Algy and Percy,
Aren't they a couple of sports."

Next, those traditional characters, a *Sister* and a *Probationer*, are introduced to us, and then an *American Visitor* (Mr. Ozanne) in a startling costume appears and joins, together with the Porter and Sir William's H.-S., *Mr. Goldmine,* in a little song on "Short Circuits." The scene ends with a song by Mr. Blake with the following chorus:—

Smoking in the College, gaining knowledge,
Knowledge of the world,
While nurses are a'walking and talking
Scandal in the Nurses' Home.
And some are helping dressers,
The compressors of patients who have lesions,
Which will shortly meet the surgeons,
That's the way we do it—at Guy's.

The second scene introduces us to Barabas Ward, where we find both a male and a female patient. Enter a *Ward-maid* (delightfully characterised by Mr. Bennett). After a little extremely amusing dialogue between the patients and the *Ward-maid*, a *Registrar* (Mr. Ozanne), accompanied by his clerks, appears on the scene, and gives us in song a *resumé* of his duties and abilities. The *Porter* comes in with a new patient, and goaded thereto by the ward-maid sings a very clever song satirising the teachers in the various departments of the school and emphasising how indispensable the laboratory assistants are. The best verse was this:—

At p.-m.'s you will find
A dispute of some kind
In spring, winter, autumn, or summer,
When Hertz so sagacious
Says the liver's lardaceous,
And Perry declares it's a gumma;
Then Herbert, indignant,
Declares it malignant,
And Hunt says a section will tell;
But it really don't matter
What they've got to say,
For the man that decides it, is Bell!

The scene closes with the discovery, behind a screen, of a *Nurse* (Mr. James), in the arms of one of the ward clerks!

The third scene is laid in an operating theatre and introduces Mr. Fawcus in the character of a surgeon. This was a very good study of a well-known surgeon, and the likeness was emphasised by the presence in the theatre of several Americans. They prepare for an operation when *Sister* (Mr. Miller) rushes in with the intelligence that *Dr. Cuthbert Wrench* and *Dr. John Corset* have been wrecked on a desert island. The *Surgeon* makes the characteristic remark, "Well, I'm sure they'll be very happy there," and proposes to leave them alone. *Algy* and *Percy*, however, now raised to the dignity of dressers, protest, and finally leave hurriedly to organise an expedition for the relief of the wrecked medicos.

The scene ends with a representation of an abdominal section. The surgeon, amid considerable excitement (and apprehension among the audience), pulls out several yards of long coloured tapes and some crackers and oranges. This finale was exceedingly well managed; it was not quite clear how far the actors might go in their desire for reality, and the anti-climax evoked roars of laughter and applause.

In the fourth scene we are transported to the Desert Island where *Dr. Wrench* (Mr. Robinson) and *Dr. Corset* (Mr. Bennett), are discovered holding an out-patient clinic for the benefit of the black inhabitants. Suddenly some warlike negroes appear on the scene, headed by a fierce-looking individual who is described as the chief medicine-man of the island. He introduces himself, however, as "*Kalar Azaar*, late Student, Guy's Hospital," After some discussion in an unknown tongue with his followers, he proposes to torture and kill the white men when the timely arrival of *Algy* and *Percy* saves the situation. The scene ends with the following chorus:—

We're going back, back, back towards the Maze Pond,
That's where we must go,
We're going back, back, back towards the Maze Pond,
To Beddard, Hertz, and Co.
We know the Staff will all be glad to see us,
That is our surmise,
They simply can't get along without their Wrench and
We are going back to dear old Guy's. [*John,*

This scene was chiefly remarkable for the extremely clever by-play of the various characters, especially of *Dr. Corset.*

The fifth and final scene shows us the Out-Patient Department. We first follow the amusing but distressing adventures of the *Borough Lady* (Mr. Fawcus) at the hands successively, of the *O.P.O.'s* (Bennett and Rook), *Mr. Blayton*, a throat-surgeon with a raucous voice, and the X-ray Department. The O.P.O.'s introduced to us an extremely clever patter song, with the refrain:—

On Wednesday I am Cameron,
On Saturdays I'm Hunt,
On Fridays I am Herbert French,
And wish I were in the Front;
On Thursdays I am Beddard,
I'm Arthur Hertz on Monday,
And people all agree
That it's very slack of me
To lie in my bed on Sunday.

The new costumes worn by Sister and the Nurses were very effective. Then we reach the exciting moment when the election of Sir Arbuthnot Lane's H.-S. is to be announced. The rival candidates are, of course, our old friends, *Algy* and *Percy*. The returning officer is the *Porter*, and the attempts of the rival candidates to influence his decision one way or the other provide him with opportunities for keeping us in roars of laughter, and his final announcement is a masterpiece of ingenuity. The scene ends with the chorus:—

We're going back, back, back towards the Maze Pond.

It is unnecessary for us to enter into a detailed criticism of the various parts. Speaking generally, however, the acting was of a very high order—better we think than at any theatricals in recent years. This feature will, we think, be one of the chief memories of the Christmas play of 1913. We cannot refrain from saying a few words about one or two of the actors. Mr.

Rook's study of the *Porter* was a wonderful piece of acting, every gesture being perfect. Mr. Bennett was, of course, the most prominent figure in all the Christmas festivities, whether as *Massa Johnson* in the Nigger, *Sister Spongiosa* at the Ward Concerts, author of the play, or in his parts of the *Wardmaid* and *Dr. John Corset*. He played both parts to perfection and brought down the House each night. Mr, Perceval, as himself, gave us a life-like and extremely amusing character study. Messrs. Scott and Sells fulfilled their parts to perfection, and Mr. Blake's singing was very excellent indeed.

One thing impressed itself upon us greatly, and that was Mr. Lucey's skill as stage manager and director. To work up material, so raw as his must have been, into so finished an article, was a fine piece of work. The thanks of both players and audience alike are due to Mr. Sherwood for his excellent work as an accompanist.

The programme was graced by a wonderfully clever caricature of "Frankie" as Nijinski by Mr. Stanley Cock, and the same artist also contributed sketches of various members of the Staff as they might have been if they had not taken up medicine.

On the first night Mr. G. Seabrooke, whom we already knew from previous years, sang in the intervals to an even more appreciative audience than last year. He again appeared on the following evening, and Miss Ella Casper also sang delightfully, Miss Agnes Casper accompanying. On the third night Mr. H. Q. F. Thompson delighted us with "Rolling down to Rio" and other favourites.

The Nurses' Entertainment.

THE Nurses' Entertainment was held in the Home on Tuesday, December 30th, and was one of the very best functions of the whole week. A novel effect was produced this year through nearly all the performers and a large number of the audience being dressed in Japanese costume. The result was very effective, especially in the latter part of the evening when the dancing was going on, the prettily coloured kimonos making a welcome change from the usual lilac uniformity.

In addition to the dancing there were fortune tellers who seemed to be eagerly sought by the men. The cap-making competition for the men produced much merriment and excitement. The successful competitor's production was very excellent; unfortunately our correspondent has forgotten his name as he was too busy trying to keep his own cap in place. He tells us, however, that the winner must have had previous practice. From other sources, however, we gather that this opinion is probably due to jealousy, as our representative's own attempt was generally regarded as being worthy of the "booby-prize."

The entertainment proper opened with an Overture by Nurses C. Pearson, Brennand, and E. A. Smith, which was very effectively rendered. This was followed by the "Tea Song," sung by Nurses E. Bevan, Carpenter, Price, and Sandford, in costume. The whole effect was very pretty and charming. Nurse Drower then gave us the "Big Bamboo" in her delightful voice. She was ably assisted by a chorus in costume, who made a very pretty picture.

We had then presented to us an amusing little Japanese sketch entitled "My Dear Little Wife," acted by Nurses Dean, Rowan, and Hook. The acting of Nurse Dean as the wife was very clever indeed. This was followed by a Minuette danced by Nurses Wacher, Taylor, Messenger, and Phillips, in costume. This item was greatly enjoyed, the magnificent dresses, the stately steps of the dances, and the young faces surmounted by white hair making together a delightful picture. Nurses Parsons and Rice then treated us to a rollicking Irish jig which was received with acclamation, necessitating an encore. Nurses Drower and De Saram then sang the "Amorous Goldfish," which was also exceedingly popular. This was followed by a Violin Solo by Nurse Smith which was quite *the* success of the evening. Her playing is exquisite. The programme concluded with an amusing burlesque entitled the "Toy Symphony," played on all sorts of toy musical instruments.

A delightful evening was brought to an end by singing *Auld Lang Syne*, and then having two more dances to show how much it had been appreciated by all.

Ward Concerts.

ESTHER WARD.

Sister Esther held her concert on Boxing Day at 3 p.m. It was quite an informal affair, and perhaps all the more appreciated for that reason. We were regaled with all the old favourites by the local stars, whose untiring energy and good humour is, as it always is, a matter for wonder. Those who contributed were Nurse Drower, Messrs. Eccles, Thompson, Parry-Price, Scott, and Sells, and the Nigger Trio. Mr. Jarvie accompanied with his usual skill. The decorations in this ward, which were carried out in trails of roses of varying shades, were very beautiful.

QUEEN WARD.

A delightful concert was held on Saturday afternoon, December 27th, in this ward. An exceptionally interesting programme was arranged, and the large audience was very appreciative. A number of visitors aided by much of the local talent contributed to the afternoon's entertainment. First and foremost was Miss Rosina Buckmann, the well-known operatic singer, who delighted the audience with Tosti's "Good-bye," the "Cuckoo Song," and a Maori Song. Miss Foxon's singing was greatly appreciated, as was also Mr. G. Seabrooke, whom we already know from previous years at the Residents' Theatricals. Miss Oldendorff delighted us again with her dancing, which was one of the best items on the programme. Messrs. Page and

Jarvie, who accompanied, were very excellent. Others who contributed were Messrs. H. N. Eccles (his "Mary Ann" was a great success), Blake, James, Attwater, Parry-Jones, and the inimitable Nigger Trio, Bennett, Harkness, and Perceval (especially Perceval!). Altogether the concert was undoubtedly one of the most successful of the week. The decoration of the ward was carried out with that taste we have been led to expect in recent years, and there was a charming tableau above the fireplace in Victoria.

CORNELIUS WARD.

Sister Cornelius was very energetic this year and held two concerts during the week. The first one was an informal one held on Friday, December 26th. All the contributors were local stars who gave us all our old and new favourites with vigour. This was one of the most delightful afternoons we spent during the week, as the voices of our "stars" had not yet become hoarse or squeaky, and nobody was yet tired out.

The second concert was a more elaborate and formal affair. Mr. B. Camplin-Smith, who is Mr. Charles Hawtrey's stage manager, very kindly brought down a party of friends for our entertainment, and right well they did it, too. Every item was really good and the whole concert passed off most successfully. Those who took part were Miss Rose Phillips (songs), Miss Letty Phillips (dances), Mr. Charles Cory (a sketch at the piano), Miss Doris Lytton who told us good stories charmingly, Miss Burlingham who sang delightfully, and Mr. Gus Garrick who kept us in roars of laughter. Mr. Leonard Chalk, Musical Director at the Apollo Theatre, accompanied throughout.

ADDISON WARD.

This Concert was held on Saturday, December 27th, and was a great success. Mr. Clarke very kindly brought down a party of friends for our entertainment, and his efforts were supplemented by a selection from the local talent. Mr. Clarke not only sang himself, but also accompanied for the greater part of the afternoon. Among those who contributed to a very successful afternoon were Mr. Clarke, Miss Forster, Miss A. Forster, Miss Clarke, Miss Vera Neve, Mr. Parker, Mr. Eccles, Mr. Hirsch, and the Nigger Trio (Messrs. Bennett, Perceval, and Harkness).

LYDIA WARD.

The great function in Lydia this year was the Christmas Tree. The distribution of gifts took place on Saturday, December 27th. The actual distribution ceremony was preceded by a Punch and Judy Show, very kindly provided by Mrs. F. J. Steward. The enthusiasm of the children over the antics of our old friend with the squeaky voice was delightful to watch, and gave us grown-ups as much pleasure as they themselves received from Punch and his dog Toby. When the show was over a great knocking was heard at the balcony door, and amid much excitement Santa Claus appeared on his sledge drawn by two stalwart retainers. The faces of the children at this stage of the proceedings were eloquent of excitement and amazement. Then the distribution of the gifts . . . . It is enough to say that our reporter in Luke reports a sudden invasion of small boys with big trumpets who murmured inarticulate words about a Christmas Tree.

LAZARUS WARD.

Strolling aimlessly, according to every-day custom, along the Colonnade on Tuesday afternoon, December 29th, a placard boldly announcing a Tango Tea in Lazarus caught our eye and filled us with excitement. We rushed eagerly up to the ward only to discover that it was one of Sister's little jokes, and that we had arrived at yet another ward concert. However, it was one of those nice informal concerts where all the local talent displays itself, and so, after a little, we swallowed our resentment and a large tea, and departed rejoicing.

CHARITY WARD.

A combined Concert and Christmas Tree was held in this ward on Monday, 29th December. Santa Claus (A. C. Clifford) was represented as a great Giant—apparently he was a very gentle and amusing giant since the children laughed so much at him that not a word of his could be heard.

After the ceremony of the Tree we were very delightfully entertained by a party of visitors from Theatreland, and in addition by a delightful maiden who charmed us with a skirt dance. Mr. Haskell also sang most humorously.

MARY WARD.

Sister Mary held a very successful Concert on Monday, December 29th. Miss Ancutt very kindly brought down a party of friends, to whom our best thanks are due. Miss Adrienne Sarti sang charmingly to us, as did also Miss Beach and Mr. Parker. Nurses Fletcher and Drower each gave us several songs in charming voice. Among others who helped to make the afternoon a success were Mrs. Calnan, Miss Thompson, Miss Garrett, Miss Hunt, Mr. Eccles, the Nigger Trio, and Mr. Hirsch. Mr. Depree accompanied excellently as usual.

BRIGHT CONCERT.

A very successful concert was held in Bright ward on Monday, December 29th. The hall, which was decorated with more than usual taste, was crowded.

The following sang and were much appreciated: Mr. and Mrs. Cuffe, Miss Allery, Miss Coxon, The Mad Wriggler Quartette. Mr. H. N. Eccles overcame his nervousness sufficiently to allow him to sing two songs. Mr. Denis Browne played two piano solos. Misses Foster and Morgan gave very great pleasure with their excellent and finished singing of Ragtime.

DORCAS CONCERT.

Monday, December 29th. Owing to the great kindness of Mr. and Mrs. Kenneth-Douglas, who brought a party to help us, one of the most successful Concerts of this Christmas was held in Dorcas on Monday. The items were varied and excellent, and a very full programme was given. Miss Dorothy Boyle kindly opened the concert with a very pretty rendering of "O Flower of all the World." Mr. Henry Ainley then gave us three recitations which were very much appreciated, and Miss Phyllis Bedells followed with two very graceful ballet dances. Mr. and Mrs. Kenneth-Douglas then gave a very amusing and beautifully acted sketch "Black Poison," which gave full opportunities for Mr. Douglas' inimitable humour, and received tremendous applause. Mr. Spiers' slight-of-hand and imitation of children, Miss Winter's very clever recitations, and two duets "Spring Morning," and "Good-night Pretty Stars," beautifully sung by Miss Doris Vane and Miss Margery Phillips, brought us to the tea interval.

The second half of the programme consisted of a short sketch by Mr. Haskell, duets by the Misses Vane and Phillips, recitation by Miss Widler, and another very pretty song from Miss Boyle. Mr. Parry-Jones with his "Glorious Devon" and "Marie, My Girl," and Mr. Thompson with "The Old Black Mare," were followed by an exquisite rendering by Miss Doris Vane, of one of Easthope Martin's "Fairings," which was one of the features of the afternoon. The "Ragtime Medicos" brought a very enjoyable concert to a close.

NAAMAN WARD.

A very successful Concert was held in this Ward on Tuesday, December 30th, 1913, and a very good programme was given. A piano solo by Miss Bladen opened the concert, and was followed by some charming songs by Mrs. Taylor, including "The Little Grey Home," which was much appreciated.

Some very pretty and effective dances in costume were then given by The Misses Woolnuth and Miss Lamb, which were much applauded, and songs by Miss Medlock and Mr. Parry Jones, followed by a Scotch dance by Miss Lamb, occupied us until tea-time.

After the interval Mr. Parsons gave some very entertaining music sketches and comic songs, and then Mr. E. H. Mills, well-known for his lightning sketches, thrilled us by his skill with the pencil, and the children were delighted with his clever caricature of Sister Naaman.

The "Ragtime Medicos" again entertained us and were very popular, while Mr. H. N. Eccles brought down the House as usual

Some more very pretty dancing by the Misses Woolnuth, and some clever impersonations by Mr. Parsons, made way for the final entertainment by Mr. Perceval's troupe, which was very well received.

EYE WARD.

A delightful concert was held in Barnabas on Tuesday, December 30th, when a large number of patients and visitors were enabled to enjoy a most attractive programme. Miss Scott Turner sang charmingly to us, and Miss Olive Turner was greatly applauded for her songs at the piano. Mr. Charles Corry was of course inimitable. Miss Lethbridge was delightful both in her songs and in her whistling. Among others who helped were Mr. Eccles, the Sisters Spongiosa, and Messrs. Attwater, Morgan, Sheldon, Ryley, and Lawson. Mr. Denis Browne accompanied before tea, and afterwards Mrs. Ormond very skilfully and kindly undertook his duties.

ASTLEY COOPER WARD.

This concert always looked upon by the men as *the* chief concert of the week, was held as usual on Wednesday night, December 31st. The ward was full to overflowing and everything passed off with the utmost enthusiasm if, perhaps, with less noise than in former years. We heard, again, to the accompaniment of rousing choruses all the favourite songs of the week.

Mr. Eccles gave us the "Village Pump" with great effect. Mr. Parry-Jones's "There's a Girl in Savannah" was uproariously greeted. The Sisters Spongiosa in costume gave us of their best and were, of course, a great success. Their second appearance in kimonos as the Sisters Hagiama was a brilliant thought and brought the house down. We were delighted to hear Mr. Lucey revive his great success, "Razors." Many others contributed to make a thoroughly successful concert which concluded with cheers for Sister Astley Cooper.

The Bonfire.

THE New Year was again ushered in with appropriate ceremony in the Front Quadrangle on Wednesday night. From eleven o'clock onwards, hordes of wild-eyed and dishevelled students rushed back and forward along the Colonnade, each bearing a mighty burden of brands for the burning. At intervals there was the shrill blast of a whistle, followed by warning cries, and then to the accompaniment of hoarse shouts and yells, a truck-load of fuel would be rushed along the Colonnade and hurled down the steps to swell the mighty pyre. A few minutes before midnight, when all was in readiness, the great heap was set alight, and a circle formed around it. In a few minutes the blaze had become so fierce that those who had been shivering on the balconies began to find it uncomfortably hot, and the poor pigeons, rudely disturbed from their ledges, circled wildly round amid showers of sparks. Then a hoarse murmur of Auld Lang Syne was heard, and the great human ring circled rapidly and erratically round the blaze. The President of the Residents, and other heroes of the day, were next honoured at the risk of their lives by the exciting chariot ride round the fire. Sir Cooper Perry, the Matron, the Sisters, and others, were then informed that a black-faced, hoarse-voiced crowd had its "eye on them." General cheers for all, and 1914, with all it may portend, had arrived.

Guy's Hospital Physical Society.

Discussion on the Treatment of Syphilis.

Held on Saturday, December 6th, 1913,
Mr. T. I. BENNETT in the Chair.

After the President had introduced the speakers, Major Pollock, R.A.M.C., opened the discussion.

Major POLLOCK: Mr. President and Gentlemen,—The treatment of syphilis, in common with that of other venereal diseases, has in the past received scant attention from the medical profession in general. Two circumstances have contributed to bring about this unfortunate state of affairs, viz :—

In the first place, the far-reaching effect of these diseases on the health of the community in general and on that of the infected individual in particular was not fully appreciated, while the way in which these diseases are most commonly acquired was held to deprive the sufferer of any claim to sympathy.

Secondly, our ignorance of the pathology of these diseases prevented us from employing really efficient treatment.

These adverse influences will soon be a thing of the past; the recent appointment of a Royal Commission to investigate the prevalence and best forms of treatment of venereal diseases is evidence of the fact that their importance to the community has at last been recognised, while the work of Schaudinn, Wassermann, and Ehrlich, among others, has placed efficient treatment within our reach.

Time will only permit of a limited discussion on the treatment of syphilis, as to go into details would occupy several evenings. I therefore propose to take mainly the present treatment of syphilis, which would, however, not be complete without a brief reference to its Prevention, Diagnosis, Prognosis, and its Effect on the national health.

Prevention.—In the great majority of cases syphilis is contracted by promiscuous sexual intercourse. If continence were universally practised by all unmarried persons, syphilis, as well as the other venereal diseases, would speedily cease to exist. This fact should be impressed on all young men and women, especially those who have to leave home to earn their living. As the result of economic pressure or thoughtlessness a certain number will persist in indulging their sexual appetite in spite of all moral exhortations or warnings as to the risk of doing so. These persons should be instructed to use some form of protection, either a condom or to rub a 30 per cent. calomel ointment into the genital organs immediately after the act. The object in giving this instruction is not to enable these persons to indulge in sexual intercourse without running any risk of contracting venereal disease, but to protect them from becoming infected and so acting as agents for disseminating syphilis and possibly of begetting syphilitic children.

The next important step in prevention is to provide treatment by *Experts*, free of charge, or at a very low cost, and without stigma. I think all of you who have had experience will agree that the diagnosis of syphilis requires the services of a skilled laboratory worker and that the treatment should only be entrusted to a medical man who has undergone some special training in the technique of injecting mercury and salvarsan. Lock hospitals should be abolished, and in their place every general hospital should have a dermatological department with special wards for the treatment of venereal diseases. This plan has been in operation on the Continent for many years and has been found to work very well. The student is thus enabled to acquire a thorough knowledge of the subject and patients are not afraid to apply for treatment. With our latest methods of treating syphilis the period of infectivity can be reduced to something like a week in most cases, as compared with our former treatment when the period of infectivity probably lasted the best part of a year, or in many cases longer. If this treatment is freely made use of by infected persons among the general population, and especially by prostitutes, doctors, and nurses, who have the misfortune to become infected during the exercise of their profession, the number of fresh infections would be enormously reduced.

Doctors and nurses attending syphilitic patients, or those suspected of being infected, should either wear rubber gloves or at least have beside them an ointment containing 30 per cent. of calomel; in the event of any breach of surface occurring it should be thoroughly rubbed with this ointment. A 5 per cent. calomel ointment could be used as a lubricant by students engaged in district midwifery work without causing any harm to the patient, while protecting themselves from the chance of accidental infection.

Diagnosis.—Up till the year 1905 no one knew the actual causative agent of syphilis, and consequently the diagnosis had to be formed from the clinical appearances alone. Hardly any disease presents such different manifestations as syphilis, and we now know that it may also cause pathological conditions which were not formerly known to be due to syphilis at all, hence some patients were unjustly labelled syphilis, while a great many more who should have been called syphilis were not. I shall not spend more time on the clinical manifestations than just to say that when you find a skin disease which does not tally in some important symptom with the accepted description of the disease which you presume it to be, or when you find some breach of surface will not heal up when properly treated, just suspect syphilis and apply a serum test.

The diagnosis of syphilis is made in early cases by finding the spirochæta pallida, and in later cases by testing the patient's serum.

The Spirochæta Pallida.—A drop of serum should be expressed from the deep layers of the sore and examined by dark-ground illumination, Burri's Indian ink method, or by staining a slide. The dark-ground illumination is the quickest and simplest of all the methods and is one which should be practised in all out-patient departments. Staining should be reserved for slides which cannot be examined at once.

The Wassermann Reaction.—When the sore has become indurated, a positive Wassermann reaction is obtained in the great majority of cases; in the secondary stage in about 90 per cent. and in late syphilis in roughly 60 to 80 per cent. The reaction also occurs in certain other diseases, *e.g.*, malaria, yaws, trypanosomiasis, and in some of the specific fevers. It is not, therefore, present in every case of syphilis or confined to syphilis alone, still, in the absence of other diseases which cause a positive reaction, it is a test of the greatest value in diagnosing the presence of syphilis in cases which do not happen to present any well-marked signs of the disease, especially in diseases such as aneurysm, affections of the central nervous system, etc. The reaction also affords valuable information as to the effect of treatment.

A positive Wassermann reaction may be obtained in early cases after the injection of a small or provocative dose of salvarsan. Noguchi's "Luetin" reaction consists in injecting a small quantity of an emulsified culture of spirochætes hypodermically; if syphilis is present a nodule forms at the site of the injection.

The cerebro-spinal fluid may be examined for the presence of leucocytes; in syphilis there may be as many as 1,500 per c.mm. for the most part lymphocytes. The Nonne-Apelt, Ross and Jones, and Noguchi tests are chemical tests for the presence of globulin and nucleo-albumins; their presence indicates a pathological condition, although not necessarily the presence of syphilis.

Treatment.—Up till a few years ago the treatment of syphilis was most unsatisfactory, because we could not with certainty diagnose the presence of syphilis in its earliest and in its later stages, and, further, we had no means of testing the effect of the treatment employed.

In the numerous cases in which the presence of syphilis was suspected, but not definitely known, a precautionary course of mercury was ordered. This had the effect of masking the usual signs of the disease, of making the patient believe either that he was cured or that he never had been infected; in either case he gave up treatment in a short time, with the result that in a certain proportion of these cases the patient became a victim of one of the manifestations of late syphilis. That all was not right was dimly appreciated, as it was a common saying that mild attacks of syphilis were often followed by late tertiary troubles.

In Great Britain the favourite forms of treatment were a mixture containing perchloride of mercury and generally potassium iodide as well, for it was known that the iodide caused the absorption of gummata, therefore it was usually added to mixtures prescribed for patients suffering from primary sores; pills or powders containing mercury and chalk or blue pill were also largely employed. The dose of mercury varied widely according to the fancy of the surgeon; the duration of treatment also varied largely, but depended in the main on the patient's own ideas. Most patients were lost sight of after a time until a relapse took place and even then they frequently patronized some other hospital or practitioner; in short, the treatment was without any system, and the results were in general unknown, so that, to use an Irishism, a doctor could not assure his patient that he was cured till he was dead.

On the Continent things were a little better, as inunction was more generally employed and there was some attempt to maintain treatment in systematically arranged courses for two years or longer.

I do not think we need spend more time in discussing our former sins of omission, and I propose to pass on to the modern treatment of syphilis in the army.

The systematic treatment of syphilis in the army dates from 1904. The injection of mercurial cream was advocated by the late Colonel Lambkin at the close of the last century. This marked a great advance in the treatment of syphilis, but there were a certain number of fatalities in connection with it. The whole question of the treatment of venereal diseases having assumed great importance, a Sub-Committee of the Advisory Board for Army Medical Services was appointed in 1903. As a result of its work a definite scheme of treatment was drawn up. This scheme advised a course of treatment lasting two years; alternative plans were given, but in general it favoured treatment by injections of mercurial cream. The injections were given in four to five courses with intervals of rest, the total amount of mercury injected being 27 grains. At the same time a Syphilis Register was introduced. In this the name of every man whose disease was diagnosed syphilis was entered, and it was not removed until he had completed a full two years' course of treatment and had remained free from symptoms for twelve months. The results of the injection treatment were greatly superior to those previously obtained, but in a certain number of cases clinical relapses occurred. In order to estimate scientifically the results of this treatment, Colonel Gibbard tested the serum of 289 patients who had completed the two years' treatment; in 42 per cent. the re-

action was positive, or, in other words, we only succeeded in curing less than half of our patients.

Salvarsan. — The introduction of salvarsan has effected a great advance in the efficiency of our treatment, although mercury still retains an important place as an antisyphilitic remedy. The great advantage of salvarsan is its rapidity of action; it thus reduces the period of infectivity and inhibits the noxious action of the spirochætes and their products on the tissues of the body. When first introduced it was hoped that one injection, or at most two, would cure the disease. Experience has shown that this is not the case. The plan of treatment which was being carried out at the Military Hospital, Rochester Row, up till this autumn was as follows:—As soon as the diagnosis was made, an injection of 0·6 grm. of salvarsan was given intravenously; this was followed by nine weekly injections of mercurial cream each containing one grain of mercury; a second injection of 0·6 grm. of salvarsan was then given. The man's serum was then examined at the end of each three months; if a positive reaction was obtained within twelve months after completing the treatment another injection of salvarsan and a further course of mercurial cream injections was given.

Colonel Gibbard and Major Harrison are not yet satisfied that this plan of treatment is the best that can be devised, and they are now trying a more intensive course of treatment.

In order to compare the two years' course of treatment by injections of mercurial cream with the combined mercurial and salvarsan course, Colonel Gibbard and Major Harrison collected and abstracted a number of syphilis case sheets of men who had been treated under one or other of the two plans. The tabulated results were as follows:—

Mercury alone.—In 378 cases, 315, =83 per cent., had one or more clinical relapses, and the average time lost while in hospital or attending as an outpatient was 83·8 days per case.

Salvarsan and Mercury.—Number of cases 152, of whom 6=3·9 per cent. had a clinical relapse and the average time lost in treatment was 41·0 days per case. Striking as these results are it is hoped to obtain better still by giving three injections of salvarsan at intervals of five weeks and ten injections of mercurial cream at intervals of a week. Of 91 cases which received this treatment not one had relapsed clinically or given a positive Wassermann reaction at the end of six months after completing the treatment. To those of us who have to treat cases of malignant syphilis with extensive necrosis which resisted mercury and the iodides, these results are almost incredible. I have seen one case in which extensive sloughing of the nose and palate was steadily progressing in spite of mercurial treatment, but in which the process was brought to a standstill in 24 hours, and the whole lesion healed in 14 days as the result of a single injection of salvarsan.

One word of caution, the injection treatment must not be attempted by untrained persons. In addition to ordinary surgical cleanliness, the main risk in injecting mercury is of doing so when the patient is suffering from nephritis as in this condition a few injections may bring about a fatal result. The injection of salvarsan requires more care and skill and cannot safely be carried out in the out-patient department. The patient must be carefully examined to exclude nephritis or lesions of the central nervous system, and he must be kept in bed for 24 hours and not be subjected to any excitement or allowed any alcohol.

One other point in treatment may be mentioned. In primary cases the initial sore should, if conveniently situated, be excised. If this cannot be done an attempt should be made to destroy the spirochætes by ionization. The positive pole should consist of a small swab moistened with a 1 in 2000 solution of perchloride of mercury and a current of 4 to 8 milli-ampères should be passed for ten minutes at a sitting. Three or four applications will destroy most of the spirochætes.

Prognosis.—The prognosis depends largely on how soon after infection the treatment is begun. To illustrate this I will quote some of the results obtained at the Military Hospital, Rochester Row.

In seventy cases treatment was begun in the primary stage; of these three had a clinical relapse, and in five a positive serum reaction was obtained within twelve months after the completion of treatment; the percentage of total relapses was therefore 11·4. In 130 cases similarly treated, but not till the secondary stage had set in, the percentage of total relapses was 33·8. So that when treatment was not begun till the secondary stage was reached the failures were three times as numerous as when treatment was begun in the primary stage.

The prognosis also depends very largely on the actual treatment employed. Taking the statistics obtained at Rochester Row, when salvarsan alone was given the percentage of total relapses was 33·3; when three injections of salvarsan and four of calomel were given the percentage of total relapses was 25; when two injections of salvarsan and nine of mercurial cream were given the percentage of total relapses was 23. The total number of cases was roughly 200, and the observations were made twelve months after completing the treatment.

We may, therefore, hope that in future we shall be able to cure at least 75 per cent. of syphilitic infections, or possibly more. It is also possible that when these cases have been under observation for a longer period, the percentage of positive reactions will diminish as the result of the curative powers of the body.

At the 17th International Congress of Medicine, Wassermann laid great stress on the value of early treatment. He said that when efficient treatment is applied soon after infection it is a comparatively easy matter to convert a positive into a negative reaction, but when a positive reaction has been in existence for some time it is only with great difficulty that it can be converted into a negative one. He also advised that

when treatment has been completed and within a year of infection having taken place, the cerebro-spinal fluid should be examined; a positive reaction indicates that the central nervous system has been attacked, and that future trouble will certainly ensue unless energetic treatment is applied at once.

Effect on the National Health.—I had intended to say something about the effect of syphilis on the national health, but have not been able to find any reliable statistics as to the prevalence, the morbidity or mortality due to syphilis.

Dr. R. W. Johnstone in his report on venereal diseases to the Local Government Board, discusses the Registrar-General's Returns, and shows that although the death rate per million living persons from syphilis has fallen from 89 in 1875 to 46 in 1910, still the death rates from General Paralysis of the Insane, Locomotor Ataxy, and diseases of the blood vessels has risen. In 1891 the combined death rates from syphilis and diseases of the nervous system, and of the blood vessels which may reasonably be regarded as having been caused by syphilis, amounted to 582 per million; in 1910 the combined death rates of the same diseases was 832. These figures do not include abortions and still-births due to syphilis.

So far as I know there are no statistics as to the number of fresh infections annually. Douglas White, at the discussion on syphilis held at the Royal Society of Medicine in 1912, applied Blaschko's figures for Berlin to the population of London, and estimated the annual incidence of fresh infections with syphilis at about 40,000. This is, of course, merely an estimate which may or may not be approximately correct. I do not know of any figures to show the economic loss caused by syphilis in its many manifestations.

Barrett made a serum examination of all patients attending the Eye and Ear Hospital in Melbourne, and found that in roughly 15 per cent. of the cases there was a positive reaction.

The truth is that we are only just beginning to realize how many different manifestations of disease are really due to syphilis. Since Wilks showed that visceral gummata are the result of syphilis, the list of pathological conditions resulting from the activities of the spirochæta pallida has grown into a lengthy one.

I think we may hope, in view of the great advances in our scientific knowledge of syphilis and its treatment, that in the future there will be a great diminution in late manifestations.

DR. EYRE: After the masterly survey of the whole subject by Major Pollock—prognosis, diagnosis, and treatment—the task of subsequent speakers is rendered much easier, because each one will confine his remarks to that part of the subject which interests him most keenly. With this aim, my remarks will be chiefly directed to the aspect of diagnosis. The diagnosis of syphilis comes into the province of the bacteriologist, since it is a very small micro-organism which causes it. The methods may be divided into two or three groups. First, we may diagnose a disease due to an infecting organism, and demonstrate the specific organism. That is the easiest, the simplest, and the most conclusive way. The next method we may adopt is proving the presence of the specific antibodies in the patient which are the result of the attempt of the body to get rid of the infection. That is not so easy a matter, and requires some little technical skill. The third method depends upon the clinical effects of the hypersensitiveness of the patient induced by the infection. It is parallel with the skin reaction in tuberculosis, that known as the von Pirquet. I am leaving the matter of clinical diagnosis, which, after all, is merely the result of experience—not only one's own experience, but the experience which has been handed down to us by our predecessors, because clinical diagnosis can only be presumptive diagnosis. There are many conditions which simulate syphilis and which are not due to the invasion of the tissues by the spirochæte, which is the causative feature. So we may disregard the clinical symptoms for the moment. I will leave those to others. We will deal only with the diagnosis of the disease which will be conclusive, and which will possibly confirm, or it may disprove, the clinical diagnosis.

First of all, until recent times, as Major Pollock has told you, we were unacquainted with the causative agent in the production of syphilis. Owing to the work of Schandiun and some of the French observers since we have been able to recognise the causative organism as the spirochæta pallida, or, as it is now more correctly termed, the Treponema Pallidum. This is a very minute organism, in the shape of a cylindrical rod, which has a corkscrew appearance upon it. It is a highly motile beast, and can get about quickly. There are three ways in which we can demonstrate the presence of this organism in initial lesions of syphilis. The first is by demonstrating the organism on the dark ground field. That is, a modification of light to your microscope field by a dark ground stop. This enables you to see the organisms which are present in the film or fluid material as white points or lines on a dark ground. The spirochæte being motile, that property renders its presence fairly easy of detection. This is the most accurate way of observing the treponema pallidum. Until a certain amount of experience has been gained in the observation of the spirochæte by the dark ground illumination I do not recommend you to trust entirely to this method, but you should confirm it by the second method, which is easier and simpler, namely that of Birri. By this method you mix some of the material with Chinese ink and examine with a one-twelfth oil immersion lens. You can pick out the spirochætes readily; but there is very great difficulty in swearing absolutely to the spirochæte. There are numerous organisms isolated from other situations in the body which have nothing to do with syphilis, and particularly I would

mention the spirochætes found in the pockets round the teeth of people affected with pyorrhœa alveolaris, also in carious teeth, which are very much like the organisms which cause syphilis. Many of these are either non-motile, or only sluggishly motile, and some have characters which enable you to distinguish them from the treponema pallidum. The third method which Major Pollock mentioned is an exceedingly uncomfortable one; namely, the method by which you stain the organism. This was probably the first method which was used. Whenever a new discovery is made, the earlier observations which led up to it are found to be of the laborious type. The staining of the treponema pallidum is one of the most wearying and difficult manipulations you can conceive. There is all sorts of muck in your preparation, and it was the bad staining which resulted from this which led to the name "pallidum." Of these methods the best is the dark ground method, showing the organism up as a white spiral against a dark background. The next best method is the Chinese ink method; and the least satisfactory is the staining method, and you will probably have to make a prolonged search before you can see with it.

The next method we can employ is that which deals with the demonstration of the specific anti-body. And in this connection one, of course, means the Wassermann reaction. This reaction has marked a very great advance in the diagnosis of syphilis, because in many of the later manifestations of syphilis the treponema is not found with readiness. But in the blood serum you can prove the presence of a body which will unite with the specific antigen. Theoretically, this Wassermann reaction is an exceedingly accurate one; for when Wassermann first elaborated the method he used an alcoholic extract of fætal liver; and the first idea must have been that this alcoholic extract contained, largely, protozoal protoplasm of the spirochæta pallida, and as such it should have been a true antigen. But later observation showed there was a big fallacy: that the bulk of the stuff which we got into our alcoholic extract was not protoplasm of the protozoon, but was lipoid material derived from the tissue of the liver. Whether these lipoids were altered from the normal lipoids by the action of the spirochæte was another matter. Further observation showed you cannot get a similarly active antigen from normal tissue.

With the exception of a few other protozoal diseases, and a transient reaction which makes its appearance in some of the acute infections, the Wassermann reaction is practically specific for infections due to the spirochæta pallida. The ideal antigen, of course, is one which we hope in a short time to use, and which has been rendered possible by the observations of Bouchet, who has now succeeded in cultivating the treponema pallidum under artificial conditions in the laboratory. As soon as that is a feasible procedure in laboratories, we shall use not an alcoholic extract of syphilitic liver, or normal organs, but we shall use an extract or emulsion of the treponema pallidum. Then we shall have a specific reaction and be able to eliminate fallacies which occur with the present reactions. Until that comes about, the objections I have mentioned will still hold good. But there are other objections, and I wish to mention two or three points in connection with the Wassermann reaction, for there are two or three fallacies which we have to guard against, and which we have to discount in assigning a true value to reports received from the laboratories.

First of all, there is the effect of treatment, and I put that first, because it seems to be the usual thing to diagnose syphilis on the discovery of the spirochæta pallida and then start away with treatment at once. In this case the serum taken for the Wassermann reaction would give a negative result, and the physician or surgeon who made the original diagnosis would wonder whether he ought to hedge or stick to his first diagnosis. The treatment of the patient with mercury, and, to a lesser extent, with iodide of potassium, does give rise to a number of negative reactions which should not occur.

Next, these reactions may go wrong for some reasons in the technique of the examinations. Without going into the whole of the details of the Wassermann reaction, which would take up more time than I am entitled to occupy, one may say that there are two or three reagents which have to be standardised very carefully. In this test, as I have said, we have not an ideal antigen, but in the future, and the not very distant future, we hope to have that. Secondly comes the question of the patient's serum. I have mentioned that treatment may nullify our observations in the laboratory. There is another point. The original reaction, as described by Wassermann, included the inactivation of the serum of the patient, the destruction of the normal complement without interfering with the specific syphilitic anti-body which should be present. The method was to heat the serum to 55° C. for half an hour, the inference being that at the end of that time the complement alone was destroyed. Many years ago, when we first started this test, we were very worried by anomalous reactions, and we found that the serum inactivated by heating often gave us results which did not correspond with the clinical or microscopical findings. We tried various other devices for the inactivation of the serum, to get rid of these things. Within the last year Noguchi has shown, by a series of very carefully worked out quantitative examinations, that if you heat the specific serum up to 55° C. during the first five minutes you lose a great deal of the specific anti-body, and during the remaining twenty-five minutes only a small further quantity goes. So at the end of your inactivation period, if you are dealing with the old original Wassermann, you have lost 50 per cent. of the anti-body,

and you can use a very much larger quantity of serum so as to obtain the same result. We got over our difficulty here by allowing the serum to stand under certain conditions so as to destroy the complement naturally without the application of excessive heat.

There is a third factor which introduces fallacies. Guinea-pigs are used because they have the most consistently large complement in their serum of any laboratory animals. But these vary enormously in their complement content. And this factor, which usually is not standardised, should be standardised carefully for every test which is carried out.

As Major Pollock told you, the value of this positive reaction is very great, provided you can eliminate those two protozoal diseases, and the transient reaction which sometimes is given by a specific fever. But it is true in only slight degree. In tertiary cases you get a reduction in the positive Wassermanns to 80 per cent., and in the parasyphilitic diseases—tabes and general paralysis—the carefully-taken reactions give 80 per cent.

The third method of diagnosis, that which brings into view the hypersensitiveness of the body to protozoal toxine, is carried out by a means which is comparable to von Pirquet's skin reaction, by luetin emulsion, an emulsion of the spirochæta pallida. That has been rendered possible by the observations of Noguchi. It provides a salt solution of the extract, a few drops of which squirted into the true skin causes a very definite reaction, which generally appears in from 24 to 36 hours. There are a group of torpid cases where first there is an ordinary tiny blush round the site of the puncture. That clears up, and ten to fourteen days later a definite papule is seen, which is associated with the normal positive reaction. This reaction is of very great value in late syphilis. In the early cases it is not so well marked, perhaps. In the late secondaries and tertiaries—the very late stages of the disease—you get an intensive reaction from this, which may go on to a pustular eruption round the region of the papule. So much for diagnosis.

Now a word or two about treatment. In the old days we gave mercury only, and there is no doubt that in those days there were a number of cures of syphilis due to mercurial treatment alone. Owing to the observations of Ehrlich we have now been provided with a new drug, salvarsan, which has completely revolutionised the treatment of syphilis. In the old days there was mercurial treatment, running for months and years, and during months of that time the patient was in an infective condition. But now, with the use of salvarsan, you can be certain that in twenty-four hours your patient is no longer in an infective condition. In this way you save innocent sufferers and children from further infection. The majority of cases of chancre of the eyelid I have seen have been small children; the other cases have been those in which a workman has licked a piece of steel out of a fellow workman's eye. Most cases of sores on the lips of children have been due to kissing, and they, again, are innocent sufferers, but they are eliminated by the salvarsan treatment. This treatment clears up all the obvious lesions rapidly, whether they are primary, secondary, or tertiary. And it is the Benedick's blessing, in that it enables a man to get the evidence of his lapse cleared up quickly, whether the spirochæte infection is cured or not. In the early days of salvarsan, one dose was said to cure, but the hopes then held out have not been realised. No doubt many cases treated by salvarsan in the early days of the drug were cured. But you have also to take the possibility of re-infection. I have had under my observation two cases in which that has occurred. There is no doubt you will get a larger number of relapses if you do not use salvarsan until the onset of the late secondaries. With this in mind, it was realised that the next step was to give several injections of salvarsan, but people who did that did not realise the original principles on which Ehrlich had been working when he elaborated salvarsan. He had arrived at the construction of "606" as the result of previous work on trypanosomes and sporulosis, and in those protozoal infections he found that he could kill off, perhaps, 90 per cent. of the protozoa in the animal's body, but the remaining 10 per cent. or so were resistant to the drug, and it was evident that in order to destroy those he must use some other drug, one to which they were not resistant. It is probably the same with salvarsan: one kills off many of the spirochætes present in the system, but the remainder is what is known as "arsenic-fast"; they will not readily succumb to further doses of arsenic. Obviously, then, it was necessary to alternate drugs.

Military experts have been working on the alternating treatment of salvarsan and mercury. This is undoubtedly the correct method of procedure, and the one which will give the best results. As to the number of injections of salvarsan or mercury which should be given, people differ. If you can keep your patient under observation and frequently test the serum reaction, remembering it may persist as positive for a month or five weeks, you should re-commence the treatment at this time, and probably the best plan is to give the smallest amount of the drug which you can manage. With regard to neo-salvarsan, this has been produced as an easier and simpler method of introducing arsenic into the system. The only point to remember is that its action is not so rapid, and that it is exceedingly toxic unless it is used immediately it is prepared. It is the only one of the arsenic preparations whose use I have seen followed by a rash. The first one was brought across by Mr. Brown, and the case was seen by Sir Cooper Perry and considered by him a case of arsenic rash. And I have seen several others, all very much more severe than the original one; but apparently it is safer to use if it is given

properly, and you can get your patients under with it better than you can with salvarsan.

Surgeon SCOTT said: I think prevention should be regarded as a very important matter, as it is in the Services. Of course, ashore this is a more difficult question altogether, as this case will illustrate. One man I treated for primary syphilis had a positive Wassermann. I gave him three injections of salvarsan. His Wassermann became negative. He had mercury at the same time. Four months later he came up with a fresh infection; the primary sore was not in the same position as the other. Again he had three injections of salvarsan and the same treatment. About six months afterwards he came in with a third attack. I treated him again, but have not heard the result. Once they know that they can go ashore with impunity and rely on treatment with calomel cream, they will do so. I do not, of course, touch on the moral side. With regard to Lock Hospitals and general hospitals I feel that what Major Pollock said about Lock Hospitals will be true: people will fight shy of going to such a public institution, for they know that in a general hospital they will get mixed up with cases of all other diseases, and so there is no reason why everybody should know a man has gone there to be treated for that disease. With regard to its treatment in general hospitals, that is palliative only; you cannot follow up your cases, and you cannot carry out your treatment over a year or two. The vast importance of early diagnosis and treatment becomes more and more obvious. If you can get your cases and diagnose them before Wassermann becomes positive you will be immensely more successful. With regard to the sore, the old text-books state that if there are two sores the affection is probably benign; but we now realise that that is untrue. You almost as frequently find two syphilitic sores as one.

We had 303 cases of so-called "chancroid"—a term we employ in the Navy to denote a sore of venereal origin of undiagnosed nature; it is convenient, though not scientifically correct—and 255 of these turned out to be syphilitic. Those 303 were collected at Chatham Hospital in two years. It gives 85 per cent. syphilitic. In regard to syphilis in relation to mental disease, I tested 108 cases admitted indiscriminately into mental wards—all cases of mental disease, not specially tabes and general paralysis. Of these 108, 47 per cent. gave Wassermann positive. Another point bearing on this concerns the relation of syphilis to mental disease. During the last ten years in the Navy the case-ratio of syphilis was reduced in the same proportion as that of mental disease. Such a relation carries no definite proof, but it is suggestive. With regard to results of primary treatment, I find there were over 1,000 cases treated by mercury, 500 by injection of mercury, 500 by means ef mercury given orally. The percentage of positive Wassermanns after two years ran out at between 70 per cent. and 77 per cent. Judged by the Wassermann test, there seemed to be no comparative advantage of giving mercury by mouth as compared with injections, or *vice versa*. The chief advantage of injections is in the way one can give them. You, then, are more sure that the patient is really getting the mercury. With regard to relapses after salvarsan treatment: Of 4,200 cases treated in the Navy, the relapses after one injection were 14 per cent. After two injections these worked out at 3 per cent, and after three injections they were only ·5 per cent. Perhaps those numbers are rather small, as all the cases are not traced, but the comparative effect of only one injection is very suggestive. Everyone now realises that one injection of salvarsan is practically useless. With regard to salvarsan in comparison with neo-salvarsan: Of 2,000 cases treated by salvarsan, 48 per cent. gave a negative Wassermann three or four months after treatment. After neo-salvarsan 51 per cent. gave a negative Wassermann. You may thus regard the two as practically equal. With regard to the reactions after injections I do not think there is much to choose.

Mr. THOMPSON said: It is surprising, I think, how history repeats itself with regard to syphilis. Putting out of court the question of the spirochætes, I think Major Pollock's, Dr. Eyre's, and Surgeon Scott's remarks might almost have come out of any surgical or medical text-book of twenty years ago. I think we knew twenty years ago that syphilis was infectious, and we knew that locomotor ataxy and general paralysis of the insane—the so-called parasyphilitic affections—were due to syphilis; also the various affections of blood vessels. I remember, in 1901, Dr. Newton Pitt, lecturing on pathology, and pointing out that locomotor ataxy was due to syphilis.

The question of the treatment of syphilis, I may take it, concerns us in three ways to-night. First, I would ask your attention to this question, which has been springing up somewhat of late, namely, that of special departments. I think that question, in regard to venereal disease, is an exceedingly important one. And for this reason: I believe, in the vast majority of cases, it is not the syphilis which is known and recognised as such (which is the type of case that would go to a venereal ward or a venereal out-patient dspartment), I believe it is the unrecognised syphilis which is infectious. In spite of what Major Pollock says, I do not think cases of unrecognised syphilis are more likely to find themselves in the venereal disease department than they are at present. That question of not the unrecognisable, but the unrecognised cases of syphilis is a very important one. And unrecognised syphilis is exceedingly important with regard to children. I have recently had, at the Victoria Hospital, a case of a child with a double chancre, one on each labium majus. The child was, unfortunately, cured too quickly with mercury—two or three washings, I think, of lotio nigra. But spirochætes have been found in that child's vagina. Such a case as that we ought to bear in mind. I believe cases have been cured in the past with mercury just as quickly and just as dramatically as now-a-days with salvarsan. The type of case should be recognised, like

that child, in which the sore is cured, but the patient is in a dangerous condition for infecting other people.

The next question is that of the recrudescence of primary sores. I do not doubt Surgeon Scott's case for a moment; I think primary sores may come on afresh, that is to say, a fresh infection may take place. But I put it to Major Pollock and Dr. Eyre whether it is not possible that in such a case it is the old disease come back again. I believe in some of the cases that may be so, and I think the matter is very important, for the cases are certainly infectious.

The next question I ask your attention to is the infectivity from the discharges, and the treatment of such cases. I think this is an aspect which applies especially to dentists. The other day a patient turned up at my out-patients suffering from a primary chancre. Clinically it certainly was that, and I have found the spirochæta pallida in the man's sputum; I have sent the case to Dr. Eyre for confirmation. I think it is exceedingly important that dentists should go very carefully into this question of the saliva of their patients and its infectivity. The other day I saw as a patient, a dentist, who, I had no reason to suspect, had exposed himself in the ordinary way, but he had a chancre in the usual place; it is possible he got infected saliva from an infected mouth, and when micturating conveyed it to his penis, where it formed a sore. At any rate, the dentist should be protected against any possible disease in this way.

With regard to the use of salvarsan where there is nervous disease, Major Pollock has told us it should not be used for these. But I cannot quite agree with that statement, for in nervous disease—though my experience in that is necessarily somewhat limited—I have had considerable success with salvarsan. There is a patient attending my out-patients now who came with bladder symptoms, and it was recognised as a case of locomotor ataxy, though he only had the ataxic gait. He had neo-salvarsan in the wards twice, and he is undoubtedly much better. I told the man there was a little risk, and he was prepared to take it. Now you would scarcely notice any ataxy in his gait, and his bladder symptoms are much better. I have had another case in which salvarsan has certainly reduced the quantity of urine in the bladder, from four pints to 12 ounces. Though he is also having strychnine, I think the improvement is chiefly due to the salvarsan. I would myself take that risk if I were likely to be suffering from locomotor ataxy.

With regard to the question of the commonness or rarity of syphilis, I remember that, years ago, alcohol was considered to be the great cause of all the diseases. Sir Andrew Clark, who was, I believe, a great tea-drinker, told us that 80 *per cent. of* the cases in London Hospital were there because of indulgence in alcohol. We are now told that a great number of all cases in general hospitals are due to syphilis, and I have often wondered whether that is really the case, *i.e.*, whether these doubtful cases are due to syphilis. I agree about locomotor ataxy and general paralysis, but what of the other cases? And I would also combat the estimate made by Mr. R. W. Johnston before the Local Government Board as to the large number of new cases of syphilis in the year, namely, 40,000. I might put against that a statement made by a medical man—I admit he had not been very successful, and was migrating to Canada—that in his practice in one of the outer suburbs of London for over twenty years he had not seen a case of gonorrhœa or syphilis in practice. I will tell you the reason of that: when we get gonorrhœa or syphilis we do not go to our local medical man. Hence a local practitioner's statement as to the amount of syphilis about is fallacious. I think, at any rate, we have a reason to ask whether this estimate of forty thousand fresh cases every year is correct, and to say that, in our experience, the case is not so bad as that.

With regard to the general question of treatment, there is no doubt that with the advent of the Insurance Act, a great number of cases of gonorrhœa and syphilis come up to hospital which, perhaps, might not have done in the old days. And that will give us a clue as to treatment from the sociological point of view, which, I take it, is one of the standpoints you wish to hear about this evening. In the first place, there should be, I think, much more co-ordination between the medical man at the hospital and the medical man outside. In my experience it is a hopeless task writing to practitioners; in most cases they will not take the trouble to even acknowledge one's letter, let alone reply to it. In war, communication is regarded as essential in the securing of victory. The same thing applies in civilian practice in regard to this disease, for only by maintaining communication between the forces inside and outside the hospitals can we get the victory over the spirochætes. I would not have anything to do with notification, as such. Though I consider the Contagious Diseases Act was a good one, there were too many nonconformist ministers involved for it to be of any use. And whatever the Report of the Royal Commission may be, I propose we start some such method as this (and we must run the necessary risks of actions for slander). If a patient affected with syphilis failed to turn up for the treatment, as so many of Dr. Keith's and my own patients do fail to turn up, we should write a note to them, and ask them to come for their treatment. I believe they will turn up more if they are written to more frequently. I am obliged to you and the students for having asked me here to speak, because it is a feasible plan to work. And if they fail to turn up, I think we should be permitted to go to a higher authority, such as the Medical Officer for the place, and report that such and such a man is in an infective stage of syphilis and has failed to go on with his treatment.

And, finally, with regard to the actual place where we stand with salvarsan and neo-salvarsan, I am doubtful; I believe that, in some cases at any rate, mercury gave as good results, and as permanent.

(To be concluded.)

Ralph Wingent.

February 14–1878. December 14–1913.

"DARE QUAM ACCIPERE."

RALPH WINGENT takes his rest after a short but by no means empty life. His tangible memorial is the book on "Guy's Hospital and Southwark," which was reprinted from these columns, but quite as real is the respect and love for him in the hearts of the many men who knew him.

It is rather surprising that with his reticent character he made such a host of friends, but the fact was that this shyness arose from his dislike of talking about himself and his work. Even his own people were unaware of the first series of articles to the GAZETTE. Once his reserve was pierced he could talk well and with a mature judgment on art and literature. From his earliest boyhood he would amuse himself at drawing (with his left hand), and though he had no further training in art and classics, after he left Sir Joseph Williamson's School, Rochester, he continued both pursuits, making himself a competent and original draughtsman in black and white, and a very fair Latinist.

Those who knew him only during the last ten years can hardly realize that one year he was the School's Sports Champion, after a strenuous contest of sprint and long-distance racing, and also jumping events.

It was only after a severe turn of rheumatic fever (leaving aortic disease) that he settled down into the quiet manner by which most of us remember him. Of the loss of his career it is not necessary to speak. How could it be expected that a man whose energy was fast ebbing under the inroads of disease could stand the racket of the profession to which you have devoted yourselves. His record will live, but in another plane to that of his profession.

Soon after he went to Guy's he became intensely interested in the foundation and history of the hospital and Southwark. He searched for records of the district from every available source, and became an authority on the topography of this part of South London. Probably if he could have been planted down in Elizabethan London he would have found his way about without asking. During his last illness, his one anxiety was to finish his article for the GAZETTE, and latterly this taxed his energies to the utmost.

What was the riddle of his hold on his fellow-students? It is no secret. He liked better to give than to receive. He was always ready to do a sketch for the Christmas Play or any other object. In spite of his bad health —and many of you can imagine what he had to suffer from severe aortic attacks—he was wonderfully cheerful, never complained either as to his own illness or the uncertainty of his career. He had no personal vanities, and was only happy when doing things for other men.

It was delightful to see how the children took a fancy to him, and he loved playing with them. Making things appear on paper is fascinating to the child mind, and when one has a kind uncle always ready to make funny pictures come, no wonder he is popular.

Such was Ralph Wingent, in many respects a man of genius. Many friends will mourn their own loss, and will be glad because he is at rest. How far he would have gone in his profession one cannot guess, but that he had the nature and qualities that go to the making of a physician there can be no doubt. H.W.

Notices.

Guy's Hospital.

Applications are invited for the post of Chief Oph thalmic Clinical Assistant, vacant by the resignation of Mr. Harry Lee.

Candidates should send in their applications to the Treasurer, at the Superintendent's Office, on or before January 10th, 1914.

His Majesty's Indian Medical Service.

A competitive examination for not less than twelve appointments to His Majesty's Indian Medical Service will be held at the Royal Army Medical College, Millbank, S.W., and at the Examination Hall, Queen Square, Bloomsbury, on the 26th January, 1914, and five following days.

Copies of regulations for the examination, together with information regarding the pay, retired pay, etc., of Indian Medical Officers, can be obtained on application to the Military Secretary, India Office, London, S.W. Application for admission to the examination, with the necessary certificates, must be sent so as to reach him on or before the 13th January, 1914.

SIXTH INTERNATIONAL DENTAL CONGRESS, 1914.

LONDON, AUGUST 3RD TO 8TH, 1914.

Patron: His Majesty the King.

Much progress has been made with the arrangements for the Sixth International Dental Congress, which will

be held in London from August 3rd to 8th, 1914, under the Patronage of His Majesty King George V., and at the invitation of the British Dental Association.

The British Government has issued invitations to foreign Governments and also to the self-governing Dominions of the British Empire to send official representatives to the Congress, and several delegates have already been appointed. Invitations have been issued to dental societies and organizations throughout the world, and steps have been taken to secure as reporters or introducers of discussions in the ten sections of the Congress the co-operation of leading specialists and representative authorities in all branches of dental surgery.

National Committees are already at work in America, France, and Germany, etc. It is hoped that National Committees in all countries will stimulate interest in the Congress and enlist the active support of all eligible members of the profession.

The Committee of Organization has completed the following list of Sections, Officers, and Subjects for Report and Debate. Hon. Presidents of Sections, representing the various countries included in the International Dental Federation (F. D. I.), will be appointed. Those nominated by the U.S.A., France, and Germany appear below. Offers of papers on subjects other than those selected for reports should be made as soon as possible to the Secretaries of the appropriate Sections, or to the General Secretaries, Messrs. Norman G. Bennett and H. R. F. Brooks.

A Demonstrations Committee is being organized with Mr. T. A. Coysh as Chairman and Mr. W. F. Mellersh as Hon. Secretary.

The International Dental Congress Museum is intended to be representative of every Section of the Congress. Mr. A. Hopewell-Smith is Chairman of the Committee, and Mr. F. N. Doubleday is the Hon. General Secretary. Application forms and all information will be sent to all intending exhibitors on application at the office of the Congress:—19, Hanover Square, W.

The Hon. Secretaries of Section IX. would be glad to hear from gentlemen in all countries willing to give *short* demonstrations of lantern slides showing: (*a*) Means of affording public instruction in Dental Hygiene, *e.g.*, lecture material, charts; (*b*) Photographs of School Dental Clinics or other Institutions for Public Dental Treatment. It is hoped to make this a valuable and interesting feature of the Section.

The Rules of the International Dental Congress provide that all ethical practitioners of dentistry possessing the qualification of the country in which they received their professional education, or of the country in which they practise, are eligible for membership.

The subscription for members of the Congress will be 30s. (38 francs; 31 marks; 7½ dollars), and for members of their families accompanying them, 15s. (19 francs; 15½ marks; 3¾ dollars).

Messrs. T. Cook and Son, Ludgate Circus, E.C., have been appointed as official Hotel and Travel Agents for the Congress, and all applications should be made to them direct.

The offices of the Congress are:—

19, Hanover Square,
London, W.,

to which address all communications should be sent.

OFFICERS OF CONGRESS.

President: J. Howard Mummery, M.R.C.S., L.D.S.Eng.

Vice-Presidents: W. B. Paterson, L. Matheson, W. Guy, Dr. A. W. W. Baker, and the President of the British Dental Association.

President of Committee of Organization: W. B. Paterson, F.R.C.S., L.D.S.Eng.

Hon. Treasurer: H. Baldwin, M.R.C.S., L.D.S.Eng.

Hon. General Secretaries: Norman G. Bennett, M.A., M.B., B.C.Cantab., L.D.S.Eng.; H. R. F. Brooks, J.P., L.D.S.Edin., Glas. and I.

LIST OF SECTIONS.

SECTION I.—DENTAL ANATOMY, HISTOLOGY, AND PHYSIOLOGY.

Subjects for Report and Debate.

The Evolution of the Human Dentition.

Calcification.

Chemistry and Physiology of Saliva.

SECTION II.—DENTAL PATHOLOGY AND BACTERIOLOGY.

Subjects for Report and Debate.

The Etiology of Dental Caries.

The Etiology and Pathology of "Pyorrhœa Alveolaris."

The Pathology of the Antrum.

Pathological Conditions of the Dental Pulp.

Discussion on the British Dental Association Odontome Catalogue.

SECTION III.—DENTAL SURGERY AND THERAPEUTICS.

Subjects for Report and Debate.

(1) The inflammatory diseases of the gingival margin and periodontal membrane (pyorrhœa alveolaris).

(*a*) The clinical signs.
(*b*) Local treatment.
(*c*) Treatment by ionic medication.
(*d*) Treatment by vaccines.

Note.—It is particularly requested that all papers should be accompanied by photographs, radiograms, etc., demonstrating the progress of cases cited and the results of treatment.

(2) The restoration of lost portions of tooth substance by inlaying.

(*a*) Inlay materials and their manipulation.
(*b*) Principles of cavity preparation.
(*c*) The cement lute.
(*d*) A comparison of inlays with "fillings."

(3) Oral Sepsis.

(*a*) Oral sepsis in relation to general disease.
(*b*) The prevention of oral sepsis.
(*c*) The treatment of oral sepsis.
(*d*) The question of crowns, bridges, and dentures, in relation to oral sepsis.

SECTION IV.—DENTAL PHYSICS, CHEMISTRY, RADIOGRAPHY, AND METALLURGY.

Subjects for Report and Debate.

The uses and advantages of X-rays as an aid to diagnosis, including the differentiation of the radiography appearances of normal and abnormal tissue.

The structural and other changes arising in connection with metals used in the mouth.

The theory and practice of pressure casting. This report will be taken at a conjoint meeting with Section V. The Reporters chosen for Section IV. will deal with the theory.

SECTION V.—DENTAL PROSTHESIS.

Subjects for Report and Debate.

Articulation and Articulators.

Design and Retention of Partial Dentures.

The Theory and Practice of Pressure Casting. Conjointly with Section IV. Reporters for Section V. will deal with the Practice.

SECTION VI.—ORTHODONTICS.

Subjects for Report and Debate.

The Unification of Terminology and Classification.

The Problem of Retention, with a view to Permanence of Result and Minimum of Danger.

Nasal Obstruction in relation to Orthodontics; in two parts, viz.: (*a*) The Effects of the Secretions of the Ductless Glands. (*b*) The Effect of the Expansion of the Dental Arches, with or without the opening of the Sutures.

Root Movement.

The Relative Advantages of Fixed and Movable Appliances.

SECTION VII.—ORAL SURGERY AND SURGICAL PROSTHESIS.

Subjects for Report and Debate.

(1) Surgical Prosthesis of the Jaws.

(2) Late Results of Cleft Palate Operations.

(3) Treatment of Dental and Dentigerous Cysts.

One morning will be devoted to each subject, the rest of the time will be devoted to papers on subjects of surgical interest in the mouth.

SECTION VIII.—ANÆSTHESIA (GENERAL AND LOCAL).

Subjects for Report and Debate.

Gas and Oxygen, alone, in mixture, and in sequence for the Extraction Operation.

Gas and Oxygen Analgesia for conservative operations.

Local Anæsthesia with special reference to (*a*) Methods. (*b*) Drugs, (*c*) Sphere of Usefulness, (*d*) Contra-indications and Dangers.

SECTION IX.—ORAL HYGIENE, PUBLIC INSTRUCTION, AND PUBLIC DENTAL SERVICES.

Subjects for Report and Debate.

The Effects of Dental Treatment on National Health and Physique.

Prophylaxis at different ages.

Lantern demonstration of slides showing (*a*) Means of affording public instruction in Dental Hygiene, *e.g.*, lecture material, charts, etc.; (*b*) Photographs of School Dental Clinics, Institutions for Public Dental Service for Adults, or other Institutions in which public dental treatment is being carried out. To be contributed to by all countries willing to send representatives. It is intended that many dentists should exhibit slides showing the working of institutions, or of public instruction, and very briefly describe them.

SECTION X.—DENTAL EDUCATION.

Subjects for Report and Debate.

The Teaching of Bacteriology for Dental Students, with special reference to (*a*) the Method of teaching; (*b*) the Extent of the teaching.

A Practical Synopsis of Medical and Surgical Teaching for Dental Students.

First Principles in Practical Teaching.

Methods of teaching Orthodontics to Dental Students.

Reviews, etc.

The Nursing Mirror Pocket Encyclopædia and Diary. (London: The Scientific Press, Ltd.) Price 6d. net.

We have received the edition of this useful little work for 1914. It has been thoroughly revised and brought up to date and should prove very useful to many nurses when doing private nursing.

The Midwife's Pocket Encyclopædia and Diary. (London: The Scientific Press, Ltd.) Price 6d. net.

This is a companion volume to the "Nurse's Pocket Encyclopædia," issued by the same firm. It contains, very briefly, all the essential points in a midwife's practice and in addition much other useful information.

S. P. Pocket Guide Series. (London: The Scientific Press, Ltd.) Price 1s. net each volume. We have received the two latest additions to this useful series, namely:—

Wounds and their Management. By J. K. Watson, M.D. Ed. This is a clear and useful summary of the important points in the treatment of wounds. It should prove very useful to probationers working in the accident wards.

Surgical and Medical Dressings. By Miss M. R. Hosking (London Hospital). Far too much detail has been crammed into this volume, and in consequence it is intolerably scrappy and quite devoid of any literary skill. Most of the various methods are fully described, but there are some curious and important omissions. For instance, no mention is made of any cleansing of the patient's skin as a stage in the application of a pre-operative compress.

BOOKS RECEIVED.—*Dental Examination Papers* for the Diplomas of the Royal College of Surgeons, Edinburgh, and the Royal Faculty of Physicians and Surgeons, Glasgow. (E. & S. Livingstone, Edinburgh.) Price 1s. net. *Fellowship Examination Papers* for the Diplomas of the Royal College of Surgeons, Edinburgh. E. & S. Livingstone, Edinburgh. Price 1s. net.

The Freedom of the Press in Egypt. By Kyriakos Mikhail. (London: Smith, Elder & Co.) Price 1s. net.

Die Standische Ohrenklinik, Frankfurt a. M. By Prof. Dr. Otto Voss. Price Three Marks.

PAPERS RECEIVED.—The Stethoscope, Nursing Times, New York State Journal of Medicine, London Hospital Gazette, Clinical Journal, The Hospital, St. Thomas's Hospital Gazette, St. Mary's Hospital Gazette.

Pass List.

University of London.

M.D. EXAMINATION, DECEMBER, 1913.

Branch IV.—Midwifery and Diseases of Women.

Reginald Larkin.

University of Oxford.

DEGREES CONFERRED.

D.M.: E. P. Poulton.

B.M. and B.C.: J. F. Venables.

University of Cambridge.

MICHAELMAS TERM, 1913.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

(Old Regulations.)

Part II.—Surgery, Midwifery and Medicine.

N. Garrard.

(New Regulations.)

Part I.—Surgery and Midwifery.

P. H. Berry.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

Part I.—I. R. R. Brogden.

Appointments.

Hospital Appointments.

House Physicians.—W. R. Reynell (Dr. Shaw); J. A. Ryle (Dr. Fawcett).

House Surgeons.—O. G. Morgan (Sir Arbuthnot Lane); A. S. Seabrooke (Mr. Dunn).

Out-Patient Officers.—A. C. Clifford, H. W. Evans, A. J. E. Smith, E. S. Taylor.

Assistant House Surgeons.—E. D. Scott (Mr. Fagge); C. H. Gould (Mr. Rowlands); L. B. Stringer (Mr. Turner); N. Garrard (Mr. Hughes); W. H. Ogilvie (Mr. Davies-Colley).

Obstetric Resident.—C. H. G. Pochin.

Chief Clinical Assistants.—Neurological Dept.: W. Johnson; Children's Dept.: L. Mandel; Throat Dept.: A. M. Zamora (Mr. Mollison); J. A. Edmond (Mr. Layton).

Clinical Assistants.—Genito-Urinary Dept.: A. Tilbury; Ophthalmic Dept.: C. M. Ryley; Medical and Surgical Skiagraphic Dept.: F. A. Dick; Vaccine Dept.: H. C. Lucey and S. Keith.

Royal Naval Volunteer Reserve.

Arthur H. Crook, appointed Acting Sub-Lieutenant in the Eastbourne (No. 3) Company, Sussex Division, R.N.V.R.

Civil.

Harry Lee, M.B., B.C., F.R.C.S., has been appointed Ophthalmic Surgeon to the Leeds Public Dispensary.

Hildred B. Carlill, M.D., M.R.C.P., elected Physician to the Miller General Hospital, Greenwich Road.

Military.

Major J. H. Horton, D.S.O., I.M.S., to act as Personal Assistant to the Surgeon-General with the Government of Bombay.

Major Edgar M. Pilcher, D.S.O., M.B., F.R.C.S., Professor of Military Surgery, Royal Army Medical College, to be Brevet Lieutenant-Colonel, dated November 26th, 1913.

Papers by Guy's Men.

Hastings Gilford, F.R.C.S.: On the Nature of Old Age and of Cancer.—*British Medical Journal*, December 27th, 1913.

F. E. Shipway, M.D.: The Intratracheal Insufflation of Ether.—*British Medical Journal*, December 27th, 1913.

E. W. Goodall, M.D.: Common Errors in the Diagnosis of the Infectious Diseases.—*Clinical Journal*, December 24th, 1913.

Hugh Watts, M.B., I.M.S.: Fractured spine, Paraplegia; Laminectomy.—*Indian Medical Gazette*, December, 1913.

Major J. C. B. Statham, R.A.M.C., and Another: Note on Certain Bodies Found by Liver Puncture in a Case of Fever Associated with Splenic Enlargement.—*Journal of the Royal Army Medical Corps.*—December 1913.

Captain A. C. H. Gray, R.A.M.C.: Report on Some Observations Made and Work Done at the Pasteur Institute, Tunis.—*Journal of the Royal Army Medical Corps*, December, 1913.

Births.

CROOK.—On Sunday, December 21st, 1913, at The Goffs, Eastbourne, to the wife of A. H. Crook, M.C., a son.

COOPER.—On December 29th, 1913, at Rossendale, Clitheroe, to Dr. and Mrs. Sephton Cooper, a daughter.

Marriages.

LOBB—GREENALL.—On December 23rd, 1913, at Christ Church, Woburn Square, London, W.C., E. Leslie Martyn Lobb, M.S. Lond., F.R.C.S. Eng., of Hong Kong, China, only son of the Rev. J. and Mrs. Martyn Lobb, of Cheshunt, Herts, to Louise Josephine, eldest daughter of J. N. and Mrs. Greenall, of Nottingham.

LANGDON—SMITH.—On the 20th December, 1913, at St. Stephen's, Ealing, by the Rev. W. H. Thompson, LL.D., William Morgan Langdon, M.R.C.S., L.R.C.P., of Hillside, North Tawton, Devon, eldest son of Captain C. H. C. Langdon, R.N., and Mrs. Langdon, Winchester House, Bedford Hill, Balham, to Rosalind Aline, only daughter of Commander C. V. Smith, R.N., of 25, Ravensbourne Gardens, Ealing, and the Hydrographic Department, Admiralty.

MUTCH—LANE.—On December 23rd, at St. George's Church, Hanover Square, W., Nathan Mutch, M.A., M.D., B.C., to Eileen, daughter of Sir William Arbuthnot Lane, Bart., M.S., F.R.C.S.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 667.] JANUARY 17, 1914. [SIXPENCE.

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Passim.

WE referred last month to the formation of a Concert of Editors of the London Hospital Journals to discuss informally matters of interest to medical students and practitioners, and to arrange for concerted action in cases of interest, if and when possible. Since the inaugural meeting there have been several discussions, chiefly upon the subject of the new anatomical terminology, or B.N.A. There is, it seems, very widespread ignorance as to what the B.N.A. is, and why there should be any move towards the adoption of a new terminology at all. The anatomical nomenclatures of various countries have been built up, as was inevitable in the case of a science so ancient and one needing so little intercommunication between the workers in it, haphazardly, and with no order or method, so that the terminology of each country is full of inaccuracies both of description and language, and contains many terms both unknown to and unintelligible to a foreign anatomist. Since this was the case, it is clear that sooner or later a body of men would appear somewhere who would be imbued with that love of order and uniformity which forms so striking a feature in some characters and some nations, and who would press forward a scheme for reforming and standardizing anatomical terms. The reformers in this particular instance were a group of German anatomists, and as a result of their advocacy an international committee was formed and sat at Basle in 1895.

As a result of the activities of this committee a brand new terminology, differing markedly from all existing terminologies, was put forward for general adoption in place of the terms in previous use in the various countries which had sent delegates to the committee. This nomenclature is known as the Basle Nomina Anatomica (B.N.A.).

HOWEVER it seems that it is almost as difficult to secure the adoption of an international scientific language as it is to popularize Esperanto or Volapuk, or the other languages of a similar nature. The new terms were received with much criticism in nearly every country, the one exception being Germany where they were adopted with some modifications in the course of a few years. In this country and in France, however, they received practically no support, and for many years they were to all intents and purposes ignored. Meanwhile they made a few converts in various minor European countries, and also became very generally adopted in the United States and the Colonies.

In Great Britain the Edinburgh School alone looked with favour upon the new comers, and in spite of the fact that it was tentatively introduced into Cunningham's Text Book, it looked as though the movement for its adoption would make no headway at all. The chief objection to the B.N.A. was based upon the view that whilst many of its terms were improvements on the old one quite as many were just as objectionable upon the grounds of clumsiness or inaccuracy, or because they disregarded historical tradition.

THINGS were in this condition when in 1912 the fifth edition of the *Manual of Practical Anatomy* (small "Cunningham") appeared with the B.N.A. occupying pride of place and the old terminology in brackets. This revived the controversy in its most acute form since no other dissecting book has at present anything like the same popularity as small "Cunningham." The matter was, of course, at once discussed by the Anatomical Society, and they, we understand, determined to prepare in collaboration with the American anatomists a revised terminology for presentation before the next International Anatomical Congress in 1915.

MEANWHILE, however, numerous books, both new and fresh editions of older works have continued to appear with the B.N.A. in place of the old names. The last straw was added when the eighteenth edition of "Gray's Anatomy" showed that even the *Times* of the anatomical world had gone over to the enemy. The sudden change of terminology without official sanction by the anatomical authorities was sufficiently annoying in itself, but in addition rumour freely states that in many cases the adoption of the new names was not due to the zeal of the editors, but rather to pressure from their publishers who desired the change for reasons of their own. If this be so, the whole question assumes a different aspect and becomes concerned primarily with the more important principle of the relations between an editor and his publishers. In other words, should the public acquiesce in coercion of an editor by his publisher.

THE question was fully discussed at several meetings of the Concert –a reference to which served as an introduction to the subject—and after various proposals had been considered the following motion was carried. "The Editors of the London Hospital Journals unanimously disapprove of the issue of any book in which the new terminology is substituted for the present official terminology until the Anatomical Authorities shall have decided the matter." It was agreed to inform the chief publishers of the views of the meeting.

THROUGH the good offices of Dr. Hale White a very interesting addition has been made to the GAZETTE Museum of Antiquities. The new exhibit consists of photographic reproductions of the Special Diploma presented to Dr. Jenner, the great apostle of vaccination upon the occasion of his admission to the Guy's Physical Society as an Honorary Associate in 1802, and of the Address presented to him by the Society in the same year. The originals are in the possession of Mr. Henry S. Wellcome, who has very kindly given the copies to the Museum. Mr. Wellcome's interest in the history of Medicine is well known; he was, of course, the organiser of the Historical Medical Museum in London last year. The Diploma and Address were among the exhibits in the Museum in Wigmore.

These exhibits are of especial interest in that they recall to our minds the age of the Physical Society, which Guy's men are accustomed to claim as the oldest medical society in London, and also as evidence of the high standing of the Society and as a corollary of the Hospital even a century ago; and in this connection it is of interest to note further that Dr. Hale White has just presented to the Wills Library a book entitled "An Essay on Animal Vitality," read before the Guy's Physical Society in 1793 by John Thelwall.

THE next meeting of the Physical Society will be held on Saturday, January 24th, in the College Smoking Room, when Mr. W. M. Lansdale will read a paper upon "Locomotor Ataxia and other Parasyphilitic Affections." In common with all the other aspects of syphilis, its ravages in the central nervous system have been the subject of much research in recent years and several new facts of considerable interest and importance have been discovered. It seems probable indeed that the term "parasyphilis," implying changes of a degenerative nature due to some obscure after-effect of the syphilitic virus and not directly to the activities of the spirochæta pallida upon the tissues in question, will have in the light of recent work to be abandoned. At any rate it is

clear that we will have to modify our views upon the nature of syphilis of the nervous system, and therefore Mr. Lansdale's paper should be very interesting and productive of a good discussion. We hope that there will be even a better attendance of men than at the papers in the first half of the session.

WE would draw the attention of men, particularly those in the Dental School, to the notice we publish elsewhere of a lecture entitled "An introduction to the Study of Comparative Dental Anatomy," which will be delivered by Professor Arthur S. Underwood in the Anatomical Theatre on Wednesday, January 21st, at 4.15 p.m. Professor Underwood is too well known to all Dental men to need any introduction from us, and we are certain that his name alone will draw a large attendance to hear him. In addition the subject he has chosen, Comparative Dental Anatomy, is one of the greatest interest and is of very considerable importance. It is a subject, moreover, which will, if the indications of the direction of progress in general anatomy may be taken as a guide, attain more and more importance in future years. We strongly advise all those men, who can do so, to go and hear Professor Underwood's lecture.

WE publish this week a photograph of the decorations in Luke ward during Christmas week. As will be seen, Sister Luke chose for the main theme of the decorations large lanterns on which were "shadowgraphs" of various animals and men of grotesque and amusing shape. With the addition of seagulls and other birds hanging from the lamps and curtain-rails the whole effect was novel and very pleasing. We are indebted to the Editor of the *Nursing Times* for his courtesy in allowing us to reproduce the photograph.

WHILST we are still thinking of Christmas festivities we must congratulate the Editor of the *London Hospital Gazette* on the very excellent series of photographs of the various minstrel troupes, who apparently form one of the chief attractions of Christmas week at the "London." They are a fine tribute to the energy of the Editor and the prosperity of the Gazette.

THE "Ladies' Night" meeting of the Debating Society will be held on Thursday, January 22nd, at 8 p.m. in the College Smoking Room. Dr. Shaw, the President of the Society, will be in the chair, and the subject for debate is "That a Tax should be put on Bachelors." Mr. T. B. Layton will propose the motion, and Mr. Fitzgerald will lead the opposition. If we may take the other meetings of the present session as a criterion, the meeting should be a great success. Thanks to the energy of the Secretary, the Society which almost perished of inanition in 1912, has taken on a new lease of life, and may confidently look forward to many further years of happy and argumentative life. The Ladies' Night is the most ambitious evening of the session, and we hope that all old friends of the Society and, still more, many newcomers will help to make the meeting a success.

THE Nineteenth Annual Dinner of the Dental Society will be held on Saturday, February 14th, at the Trocadero Restaurant. The President, Mr. F. N. Doubleday, will occupy the chair. It is unnecessary for us to do more than announce the date of dinner in the case of the Dental Society since the keenness of the members is such that the function is always a great success. Tickets, price 7s. 6d. each (exclusive of wine), may be obtained from the Hon. Secretary, Mr. H. Millet, or from any member of the Committee.

THE calendars for Medical and Dental Students are now issued and may be obtained from the Medical School Office or in the Wills Library.

Pass List.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.
December, 1913.

C. H. Atkinson.
C. C. Bennett.
W. A. Flynn.
J. C. Gie.
W. A. Hawes.
C. G. Haynes.
N. Kamchorn.
*F. C. Miller.
A. Rathouse.
W. H. Steavenson.

* Awarded a mark of distinction in Physics.

Guy's Hospital Physical Society.

Discussion on the Treatment of Syphilis.

(*Continued from page 20.*)

Mr. RYLE thought that all active syphilis should be treated in one department, to which should be allocated a small number of beds. And parents of syphilitic children should receive treatment. In Mr. Ryle's experience this was usually neglected.

Mr. EDMOND said that only 22 per cent. of syphilides from Throat Out-Patients' made the necessary eighteen attendances for treatment. Printed papers of instruction and advice, however valuable, should not take the place of personal teaching, for most Hospital Out-Patients do not read what is given to them. One great advantage of salvarsan over mercury was the rapidity of its action, thus curtailing the amount of tissue-destruction.

Mr. KEITH'S experience of luetin had been unsatisfactory.

Mr. LAYTON said: I think we should feel extremely proud of the Royal Army Medical Corps, which has done more than any other body of men to put the treatment of syphilis on really good lines. What we want to consider is how to apply their lines to civilian life. It is often said that the civilians cannot treat syphilis as carefully as the Army Medical people, because they cannot get hold and retain hold of the patients. And that is quite true. What we have got to do is to induce the patients as much as possible to come for treatment. The first point I would lay stress on is, that it is the doctor's duty to tell the patient that he is suffering from syphilis. That has not been sufficiently taught in this hospital in former days. I admit it is very unpleasant to do so.

In the Throat Department nearly all the acute cases of it we get are in women, and often they are young women. It generally means a flood of tears, and a discussion of what they have been doing the last few weeks, which, as we tell them, is not to the point. But I think it does good if you make them understand they are suffering from a very serious disease, but that we can treat them if they will attend. I think our patients have attended better since we have done that.

When I started in the Department we continued treating people by the mouth until I went to Rochester Row and saw Major Gibbard giving it, and Major Probert, there. And we are now giving the "one five, one five" course: that is, one of salvarsan to five injections of mercury. I have heard it said, "it is all very well giving injections, but you will not get civilian patients to put up with it." I do not think that is so if the matter is fairly put to them, and they are told it is the best way of treating it, as I believe it is. With that idea we are hoping to introduce in my department next year a syphilis sheet, though we shall not mention the name of the disease on the sheet. This can be pinned into the out-patient letter of the same size.

When I was a student we were not sufficiently taught the importance of testing the urine in syphilitic cases. On our sheet we shall have a space for entering the result of the urine testing. But I know there are some cases which cannot attend regularly. There is one case in point, a late manifestation of syphilis. He had a severe leucoplakia, and he had been under treatment for about three years under Mr. Steward before he came under my care. He got a little better under the mercury he was given, and then he went back so much that the question of excising a quarter of his tongue has been discussed, for fear it might be a pre-cancerous condition. He works on a dredger, and only when the muck-boat comes back to port can he attend. Ultimately we gave him, on two separate occasions, an injection of salvarsan, taking him in for a day each time, and his tongue has now entirely cleared up. Whether it is absolutely cured I do not know; but the injections of salvarsan have done more for him than three years' spasmodic administration of mercury by the mouth. Mr. Thompson mentioned the teeth, and I would lay stress upon that, because in the case of throat syphilis part of the treatment is to have the mouth cleaned up. You should warn the dentist that the patient is infected with syphilis, so that he may take precautions. My experience at Guy's in the Dental department shows that that is not always done. Another point is that in the late manifestations, though you treat the syphilis you must also treat the local condition. That was much impressed upon me in Vienna; people who come with syphilitic ulceration inside the nose must receive treatment in the nose, mouth, and teeth. That is very important.

Mr. SMYTH and Mr. JAMES referred to the pain of intramuscular injections.

Mr. WEBB asked for suggestions as to the treatment of syphilis in private practice. He claimed that to be sincere and out-spoken was often detrimental to professional success.

The PRESIDENT said: I wish to ask Major Pollock a question which arises out of a statement which he made in his opening. He called attention to a speech made by Wassermann at the recent International Congress of Medicine, drawing attention to the importance of examining the serum reaction of the cerebro-spinal fluid in all cases which have been under treatment for some time. I should like him to tell us what are his views as to the ways in which such cases should be treated in the event of their giving a positive reaction. He has drawn attention to the increasing mortality from general paralysis of the insane, and locomotor ataxy; and if it be granted that salvarsan is contra-indicated in affections of the central nervous system, this remains as great a problem as it has ever been. Another point on which I should like to hear him speak is the one which Mr. Thompson drew attention to, the apparent discontinuance of the startling kind of results which we all saw when salvarsan was first introduced; and whether, in Major Pollock's opinion, the neo-salvarsan has as high an efficiency as the first samples of salvarsan had. That is

a point on which there seems to be the greatest controversy among members of the profession.

Major POLLOCK, in reply, said: With regard to Surgeon Scott's reactions after treatment by the mouth and by injection, he said there were positive reactions in 77 per cent. I have not the reactions worked out by Major Harrison, but after mouth treatment we found the positive reactions were more than twice as many as after injection treatment; and inunction treatment gave more positive reactions than injection.

With regard to unrecognized syphilis, that is a question of lack of education in the medical man; there is no other way of looking at it, I think. With regard to cases being quickly cured by mercury, they were not cured, they were only apparently cured because the superficial signs disappeared. With regard to malignant syphilis, there are quantities of cases of that. I have not been working much in England, but in the seaports it is very common. Abroad it is extremely common. It depends mainly on the source of the infection. In Malta there were two women, who came over from Sicily and infected twenty-five men in a fortnight, and one could tell, as each patient walked in, which woman he had been with. In the severe cases there was a great sloughing sore, and before that was over there was a severe rash. Mercury had but little effect on them. In Vienna, before the salvarsan was discovered, they used sarsaparilla treatment for these cases. I have no experience of cases with ataxy, but I am glad to hear that improvement has occurred after salvarsan. Still, where there is a pathological change in the nervous system, if you give salvarsan you kill the patient in twenty-four hours. We had one patient who was being treated with mercury, but he insisted on having an injection of salvarsan. He got it, and he was dead in twenty-four hours. We found a gumma in the brain, which was filled with broken-down blood, and there was some meningitis on the surface, evidently the result of the salvarsan injection.

With regard to the number of soldiers passing through the military hospitals, all the treatment is done in the centres, not in the small hospitals, and each man in charge of the treatment has been previously trained at Rochester Row—it is all Rochester Row treatment; 20 per 1,000 in the Army serving at home are getting syphilis every year. We have not got the figures absolutely. Taking 80,000 men in the Home Army, that gives 1,600 cases of syphilis. They are mostly young men, only seven per cent. are married; they are away from home and friends, and hence are more likely to fall and get syphilis than is a civilian.

With regard to treatment by ionisation, I do not know how much mercury is carried into the system by this means, but the practical result is clear, for the spirochætes disappear.

With regard to iodide of potassium, I have ordered it in pounds and tons in India, but I have never seen it cause more than temporary improvement. It will cause absorption splendidly in the case of gumma, but I do not think it has any effect on the spirochæta pallida.

There is, of course, some pain and bruising caused by the injection when the skin has not been asepticised, for there is a liability to drive in some septic hair or epidermis. But I have given it for four years, and sometimes one hundred a week, and have never had one go septic; that, of course, may have been good luck. If there were much pain the soldier would feel it, for he has to work hard, and it would be likely to touch him up. It does not prevent him riding. There will be severe pain if you put it in against a nerve-ending or some branch. I do not know how you are to avoid that, but you must take your chance.

With regard to not finding spirochætes in the sore, naturally if you dress the sore with an antiseptic- not necessarily mercury—you will not find the spirochætes. You must stop your antiseptic for a whole week. They are often more difficult to find on puncturing a gland than on puncturing the sore.

With regard to the proportion in men and women, remember it is more easy to miss a syphilitic lesion in a woman. You cannot see all the parts of her genitalia; moreover, there is not the same prominence of them as in man, and the woman often does not know she has got anything the matter with her.

You need not tell the man the name of his disease; call it trypanosome disease, or something of that, and tell him he must go through the whole treatment. Salvarsan injections are safe if there is no nephritis and no pathological change in the central nervous system, and the heart is in good condition. But the man is told to abstain from alcohol for twenty-four hours, and he must not have a train journey for at least twelve hours. You can, under these conditions, give it in the patient's home.

There is little tertiary syphilis in workhouses, because the late manifestations in these institutions are mostly parasyphilis.

In this country people seem to have very fair immunity against the severity of the disease; it is of a mild type. With a certain amount of good health, people in this country mostly tide over their syphilis, though some do not.

I do not believe that syphilis alone causes general paralysis: I think there must be syphilis *plus* alcohol, or *plus* sexual excess. Syphilis, of course, is the predisposing cause.

With regard to Wassermann's remark, that when the reaction is positive in the cerebro-spinal fluid it is the signal for urgent treatment; the treatment by salvarsan is only contra-indicated when there are changes in the central nervous system. The aim must be to give treatment before the nervous system is involved.

Neo-salvarsan was tried at Rochester Row, but it was not found to be so good as salvarsan, and so it has been given up there entirely. There is another preparation now; I saw the first injection given yesterday. I do not know what it is going to do. I think salvarsan still gives the same results as it did; neo-salvarsan, no.

It has been a pleasant revelation to me to find syphilis so well treated in Guy's, compared with what obtained when I was a student; and if the same thoroughness is carried out at all hospitals, the disease will be got rid of altogether, or will be only an exceptional occurrence, like small-pox is now.

I thank you very much for the great attention which you have given me.

The President, in the name of the Society, cordially thanked Major Pollock, and the various speakers, for their contribution to the debate.

Obituary.

DORIS DRAKE.

WE deeply regret to have to record the death of Miss Doris Drake which took place on Saturday, January 10th. While at work on Thursday her clothes accidentally caught alight, causing severe burns from the effects of which she passed away in Charity Ward two days later.

She came to the Hospital in October, 1912, as Assistant in the Out-Patient Visitors' Department, and during the short time she was here showed great love and keenness for her work, and made many friends.

The Funeral took place at Teddington on Wednesday, January 14th, the first part of the service being said in Guy's Hospital Chapel.

We wish to express our deep sympathy with her relatives.

Change of Address.

Dr. W. E. Robinson, to 6, Hertford Street, Mayfair, W. (Telephone, Gerrard, 1461).

Dr. H. A. Sanford, from Castletown, Isle of Man, to 578, Woolwich Road, Charlton, London, S.E.

G. B. H. Jones, from the Belgrave Hospital for Children, Clapham Road, S.W., to East Sussex Hospital, Hastings.

Rolf Creasy, from the Belgrave Hospital, Clapham Road, S.W., to East Sussex Hospital, Hastings.

W. A. Bulleid, L.D.S., from Guy's Hospital to 1, Burlington Gardens, W.

Isidore Samuels, L.D.S., from 28, West Southernhay, to 15, Bedford Circus, Exeter, and The Square, Seaton.

Geo. C. Steele-Perkins, M.D., Ch.M., to 30, Weymouth Street, Portland Place, W.

E. Laurence Pilbeam, L.D.S., from Royal Naval Barracks, Shotley, near Harwich, to 6, Park Crescent, Torquay.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Guy's Hospital.

List of amounts received from Patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1913. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1913.	Special Donations. 1913.	Totals for 1912.
	£ s. d.	£ s. d.	£ s. d.
Front Gate Box ...	4 7 8	—	1 12 5
Porter's Lodge ...	6 14 10	—	8 9 6
Out-Patient Dept. ...	3 16 8	0 10 0	2 3 7
Surgery...	12 16 2	—	8 5 6
Conservation Room ...	2 15 3	5 0 0	2 7 8
Actinotherapeutic Dept.	—	15 0 6	38 1 6
WARDS.			
Addison	2 3 8	3 3 0	8 17 10
Astley Cooper... ...	0 12 10	9 11 0	14 18 6
Bright	5 8 9	—	4 17 3
Charity...	4 6 10	20 5 0	20 4 2
Clinical	3 13 3	27 15 0	8 2 8
Cornelius	0 15 0	18 5 0	22 16 7
Dorcas	4 10 1	32 11 0	17 10 0
Esther	1 5 11	10 0 0	37 11 5
Eye	1 5 5	4 12 6	2 17 1
Job	6 7 6	26 6 6	15 3 7
Lazarus	1 17 0	11 7 0	25 18 6
Luke	4 3 0	41 16 0	37 9 4
Lydia	4 4 2	15 19 0	13 18 10
Martha...	2 14 3	61 16 0	69 7 6
Mary	2 10 10	10 5 0	21 9 1
Naaman	5 12 10	27 3 0	38 13 0
Patience	0 18 3	10 0 0	11 2 5
Queen	5 17 4	62 12 6	27 7 3
Stephen	0 15 3	4 2 0	22 5 10
	£89 12 9	£418 0 0	£481 11 0
Totals for 1913 ...		£507 12 9	

Appointments.

Civil.

Mr. W. E. Fox has been appointed Fifth Assistant Medical Officer at Bexley Mental Hospital.

Military.

R.A.M.C.

Major William G. Beyts, to be Lieutenant-Colonel, *vice* E. M. Pilcher, D.S.O., supernumerary (dated January 1st, 1914).

Captain M. C. Wetherell has taken up duty at the Military Hospital, Fethard, on transfer from Kildare.

Captain A. M. Benett has been appointed to the Scottish Command.

I.M.S.

Captain H. C. Keates, Officiating Civil Surgeon at Campbellpore, has been appointed Plague Medical Officer at Lahore.

Affections of the Umbilicus.

CLINICAL LECTURE BY F. J. STEWARD, M.S., F.R.C.S.

GENTLEMEN,—There is now in No. 1 bed, Job ward, a small boy who was admitted about four weeks ago with symptoms of tubercular peritonitis. He had been ill for several weeks, and before admission he became much worse. When I examined him I found that his abdomen was swollen and tender all over and somewhat rigid, and the boy was obviously very ill. Moreover, the umbilicus was swollen and prominent and red, and I thought it likely he might be getting an abscess there which would open in that region. But after admission he improved for a time, and the umbilical swelling disappeared, but he subsequently developed a fæcal abscess—*i.e.*, the small intestine perforated in the right iliac fossa—and the collection had to be opened. It was with this case in my mind that I thought, as there are a number of interesting conditions in connection with the umbilicus, and as these conditions are not at all fully dealt with in the ordinary text-books, that perhaps the subject would be a good one for a clinical lecture. I shall refer to a number of cases illustrative of these conditions.

1. *Abscess.*—The case I have already mentioned illustrates the first type of affection in this region—that is, *abscess*. The umbilicus is sometimes seen to be swollen, red and tender, as was this boy's, or an abscess may have been allowed to burst—*i.e.*, there may be a discharging abscess at the site of the umbilicus.

What are the causes of *umbilical abscess?* The first point I would make is this: I believe that an abscess at the umbilicus means some intra-abdominal trouble. If there be a cellulitis or a subcutaneous abscess on the surface of the abdomen, it is very unlikely that it will travel towards the umbilicus and point there, because the skin is more firmly attached round the umbilicus than elsewhere. On the other hand, supposing there is inflammatory trouble within the abdomen, bearing in mind that the umbilicus is the thinnest spot in the abdominal wall, it is clear there would be a tendency for the pus to come through at that point. The commonest cause of umbilical abscess is tuberculous peritonitis. In the plastic type of that disease, in which the tubercles are scattered over the surface of the peritoneum, both parietal and visceral, coils of small intestine tend to become adherent to one another and to the parietal peritoneum. The effect of the disease is to cause softening, and the bowel may give way and an abscess form, or, owing to infection spreading through the diseased bowel wall, an abscess, due primarily to the bacillus coli, may form. So in an unhealthy, thin child with abdominal symptoms and swelling at the umbilicus, which is red and tender, you may reasonably suspect tuberculous peritonitis.

Other suppurative processes within the abdomen may in the same way point at the umbilicus and burst. Some time ago, a child, æt 12, was brought to my out-patients. A few weeks previously she had been in the Hospital in Mary Ward, where she had been treated for some abdominal complaint, and was sent home apparently cured. Afterwards the abdomen swelled more and the child got more ill, the umbilicus became prominent, and in that condition she was brought to me. There was considerable dulness round the umbilicus, which stood out an inch from the abdominal wall. The swelling was opened, releasing a large quantity of pus. Cultivation showed it was *pneumococcal.*

A less frequent cause than formerly is *appendicular abscess*, for appendix abscesses are now-a-days seen earlier, and opened before they burst. These abscesses used to be seen when they had burst through the abdominal wall, and some of them travelled up and burst at the umbilicus. Again, there may be an abscess at the umbilicus due to disease in the biliary region. *Acute cholecystitis* due to gall-stones may set up suppuration outside the gall-bladder, the gall-bladder may then perforate into it, and the abscess open at the umbilicus; in fact, there have been cases in which such an abscess has opened at the umbilicus and a number of gall-stones discharged, and the patient cured. But if in such a case the common bile duct is blocked by a stone, then the abscess at the umbilicus will lead to a biliary fistula Other cases of umbilical abscess have been due to injury—for instance, gun-shot injury.

Another form of abscess is that known as *urachal.* The urachus is the remains of the allantois, which normally becomes converted into a fibrous cord passing from the top of the bladder to the umbilicus. The upper portion in these cases remains pervious, and at a later period—at any time in the patient's life—such a remnant of urachus may undergo suppuration, become distended, and point at the umbilicus.

2. *Fistula.*—The next thing to consider is fistula, and first, I shall speak of fistulæ which are met with in connection with *Meckel's diverticulum.* I must remind you what Meckel's diverticulum is, and how it is formed. It is the remains of the Vitelline duct, which connects the gut in the embryo with the yolk sac, and passes through the umbilicus. Normally, the yolk sac disappears, and the whole Vitelline duct also. But comparatively frequently part of it remains, and occasionally the whole duct persists, so that when the cord separates it is opened. In that case there will be a fæcal fistula at the umbilicus, which is congenital. The fistula may be large and transmit the whole contents of the intestinal canal. In those cases there is frequently mal-development of the intestine below, *i.e.*, from one to three feet above the ileo-cæcal valve the intestine may be stenosed, or it may be in part absent. In other cases the intestine below may be quite normal, and then the umbilical fistula is usually smaller, giving passage to only part of the fæces. I have seen one case in which the intestines below the diverticulum were small and rudimentary, and practically functionless. The child was admitted into Great Ormond Street Hospital in a very emaciated condition. It was seven months old, and from birth the whole of its fæces had been passed through a large umbilical opening, so large that the finger could be inserted. There was some prolapse of mucous membrane at the side. The child was in too feeble a condition to admit of anything being done and shortly died. Post-mortem, the intestinal canal presented a very striking appearance; the small intestine below the diverticulum, and the whole of the large intestine, was very small, and clearly had not grown during the seven months the child had lived.

In some cases such an open Meckel's diverticulum may be associated with prolapse, a mass of prolapsed mucous membrane, of greater or less size, forming a tumour at the umbilicus. If the Meckel's diverticulum is quite short, the whole of it may be turned inside out and prolapsed, showing two openings at the base, leading into the ileum above and below. In other cases there is only partial prolapse. Another extraordinary thing which very rarely happens in connection with patent Meckel's diverticulum is the passage of an intussusception through it. I have a vivid recollection of a case I saw in 1895 which was admitted under Mr. Golding-Bird. A baby, four weeks' old, was brought up to the surgery with a red bleeding mass thicker than my finger and several inches long projecting from the umbilicus, and the tip of it was black. The child lived only a few hours, and the mass proved to be an intussusception of the ileum, which was retrograde, *i.e.*, it began at a point in the ileum below the site of the Meckel's diverticulum, and passed upwards along the ileum. We knew it was an intussusception, not a simple prolapse, because a probe could be passed between the projection and the umbilicus into the intestine.

In other cases, a patent Meckel's diverticulum may shrivel up so that it is quite small, and instead of fæces passing by way of the umbilicus, there is only a little mucus, and as there is always a certain amount of prolapse, a small bright red tumour is present with an opening on its surface. I have seen two such cases, and I had in each to dissect out the tumour and a length of duct varying from one to two and a half inches, leading from the umbilicus to the intestine.

Fistulæ also occur in connection with the *urachus.* These may be congenital or acquired, and complete or incomplete. If complete, urine escapes when the child cries or micturates; if incomplete, owing to the bladder being shut off from the patent urachus, there is only a discharge of mucus.

In the acquired form the urachus is patent from the bladder upwards, but closed at the umbilicus, which, however, gives way later in life. When this happens there is usually some disease of the urinary apparatus. In some cases it has been connected with the formation of a calculus in the bladder; in others with polypus in the bladder; while in others again it has been associated with stricture or other form of obstruction. In children, the straining associated with phimosis may open a patent urachus.

The size of the opening in a case of patent urachus varies very much, just as it does in the case of a Meckel's diverticulum, so that there may be only a pin-hole opening through which a few drops of urine pass, or it may be large enough to permit of considerable prolapse. In one extraordinary case a stone was extracted from the bladder by the surgeon passing his finger down the patent urachus and so hooking it out. The case was published in 1850, and I will read you a part of the account:—"J.C., an ironfounder, æt 40, has suffered for a year from frequent painful micturition, and on sounding I found a calculus. He mentions that after attempting to make water and during strong efforts at work, a portion of his urine is apt to escape from the navel, which is open, and, as

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far as he knows, this has been the case with him from birth. On subsequent examination I found that the nose of the catheter was easily made to appear at the umbilical opening, and I hoped the stone, which seemed not to be large, might without a painful operation be extracted that way." The surgeon then describes how he proposed to do this. When, however, all was prepared, and the knife for lithotomy at hand in case of failure by other means, it occurred to him to examine with the finger at the umbilicus. It readily entered and passed within the circle of the calculus, which he was then able to drag along the side of the bladder and extract. The calculus is described, it turned out to be annular, and was found to have been formed round a hair, no doubt one of the pubic hairs, which had found its way into the bladder.

Biliary fistulæ may also be present at the umbilicus. Cases of congenital biliary fistulæ have been described; these are quickly fatal. They may also be acquired, as I have already told you, in cases of gall-stones; abscesses may form and burst at the umbilicus, gall-stones may be discharged, and afterwards bile, for a greater or less period, according to the condition present.

To make the list complete, I may say there is another form of umbilical fistula which might be described as *bleeding fistula*, and which occurs occasionally from failure of the umbilical vein to become atrophied and close, as it should do, at the time of birth. In such case five or six days after birth, there is violent bleeding, which may prove fatal at once; or the bleeding may be less in amount, and stop for the time being, only to break out again and end fatally.

3. *Tumours.*—I now pass on to swellings or tumours of this region. These may be classified as congenital, acquired, fluid, solid. I will mention them in the order of their frequency of occurrence.

First with regard to congenital tumours. A considerable number of babies are brought to Out-Patients with a little red prominence a quarter of an inch or so in diameter attached to the umbilicus. These are usually called *umbilical polypi*. Sometimes careful examination reveals an opening, and it may be possible to pass a fine probe through such an opening and down a canal. In this case the polypus is usually the prolapsed part of a patent Meckel's diverticulum. It is therefore important to first ascertain in such a case whether there is any opening leading to the abdomen. If there is not, it is easy to deal with the condition by tying a ligature tightly round the base of the polyp and cutting it off, or allowing it to drop off after tying. On section, these polypi are found to consist of intestinal mucous membrane, *i.e.*, they are covered with columnar epithelium, and contain a large number of mucous glands. I think the explanation of these polypi is, that they represent a tiny bit of Vitelline duct. In connection with Meckel's diverticulum, I have told you that the Vitelline duct in its proximal part remains more or less patent. But if only the distal part, from the umbilicus to the yolk sac, remains patent, it is clear that when the cord drops off a little piece of mucous membrane will remain attached to the skin, and give rise to a polypus. Other forms of polypi are granulomata, and are due to unsatisfactory healing of the stump of the cord.

Now we come to another condition connected with the urachus, and that is *urachal cyst*. I mentioned that if the urachus is patent throughout, it may discharge urine. If it is patent for part of the way, it may discharge a mucopurulent fluid. It may, again, be closed at each end, and the portion between the umbilicus and the bladder, or part of that portion, may be patent and become distended. In that case a urachal cyst is formed, usually close to the umbilicus, and may cause a swelling likely to be mistaken for umbilical hernia. But the fact that these swellings are irreducible, often translucent, and clearly contain fluid, usually renders the diagnosis comparatively easy. They may not only appear in childhood and be obviously congenital, but they may first appear later in life. Although commonly small in size a urachal cyst may be distended to such an extent as to cause a large tumour, apparently, within the abdomen, for the urachus is only separated from the peritoneal cavity by the peritoneum itself. To give you an idea of how large they may become, I may say that urachal cyst has been mistaken for an ovarian tumour. Further, these cysts may be multiple; so that there may be a considerable number of them along the urachus. On two occasions when making a median laparotomy I have come upon small urachal cysts, not bigger than a marble, which had not previously been detected. In the first of these cases there was a single one; in the other there were two.

Another congenital swelling at the umbilicus is *congenital hernia*. A baby may be born with a hernia, of greater or less size, at the umbilicus. When this is large there may be considerable deficiency of the abdominal wall, and the hernia only covered by amnion and peritoneum, the condition quickly ending fatally. In other

cases there may be simply part of the intestinal canal present in the base of the funis, and this condition is obvious when the child is born. These cases are usually associated with maldevelopment of the intestinal canal, because the portion of the intestine which is commonly present in a congenital hernia is the cæcum and neighbouring part of the intestine. You will remember that the cæcum develops at the umbilicus first of all, and then travels round the abdomen as the large bowel is formed.

With regard to *acquired tumours*, none of them are common. First, there is epithelioma at the umbilicus, which is not at all common, and I have only seen one case. It apparently originates through irritation in an obese subject, owing to failure to keep the parts clean. A woman came to my Out-Patients several years ago with a large fungating stinking mass at the umbilicus. It had been growing some time; there were enlarged glands in both groins, and it was obvious that no surgical measures would be of use. I advised her to go to an infirmary, and I heard nothing more of her.

Carcinoma may appear at the umbilicus sometimes in a rather curious way. When there is carcinomatous disease inside the abdomen affecting some part of the bowel or stomach, there may be a spread by the lymphatics of the falciform ligament towards the umbilicus, and a growth may appear at the umbilicus. I have seen several cases in which this happened. In one case I performed an exploratory operation because it was not quite clear what the condition was. The man was under Sir Cooper Perry when I corresponded with him. The patient was admitted with a hard mass at the umbilicus, and he had had a certain amount of indigestion but nothing very definite apart from this. I found on exploration that the tumour was only part of a large area of peritoneum which was involved in carcinoma, in connection with a growth of the stomach of the "leather bottle" type. When you are confronted with such condition, therefore, it is important to examine the whole abdomen, to ascertain, if possible, whether there is any other evidence of visceral disease.

Occasionally, one sees *warts* at the umbilicus; I have seen several cases of multiple papillomata there, and the subjects were all stout people, and most, if not all, were women: they had a large fold of skin at the umbilicus, and I think the formation of the warts had some relation to lack of cleanliness. The treatment is to remove the warts and keep the parts clean.

I have left till last the commonest form of swelling at the umbilicus, namely, *hernia*. The subject of umbilical hernia is too large to deal with at the end of a lecture, but I may remind you that there are two types of acquired umbilical hernia which you have to recognize. First, there is the infantile type, in which a small hernia is present at the umbilicus, and you can feel the margin of aponeurosis round it. These usually get well, and seldom require operation. Secondly, there is the acquired adult type which is commonest in women, and is very liable to become irreducible or strangulated.

4. *Inflammation.*—Finally, there is inflammation of the umbilicus. Stout people, from want of cleanliness, may have excoriations and fissures in the umbilical region, which occasionally result in cellulitis or erysipelas. I saw one very bad case of erysipelas which started at the umbilicus and spread over the abdomen, and nearly ended fatally. And you must remember that in infants, when proper cleanliness is not maintained in connection with the stump of the funis, the granulating wound which is left after the cord drops off, may be the origin of infective conditions. I saw such a case in a baby a week old, obviously very ill. All round the umbilicus there was a red infiltrated area. The child was admitted to hospital, but died a day or two afterwards. The post-mortem showed septic infection which started at the umbilicus and travelled up the umbilical vein, which was full of pus, and would have set up a general pyæmia. When a pyæmic infection occurs in a child of that age, it is, of course, rapidly fatal.

Notices.

Newland-Pedley Gold Medal for Practical Dentistry, 1913.

Mr. A. E. Lowein, Medal.
Mr. R. J. Ryland, Certificate.

Guy's Hospital, S.E.
January 8th, 1914.

Dental Anatomy Lectures.

Professor Arthur S. Underwood has kindly consented to deliver a Lecture in the Anatomical Theatre on Wednesday, January 21st, at 4.15 p.m.

Subject:—"An Introduction to the Study of Comparative Dental Anatomy.

It is hoped that there will be a large attendance.

"Eye" in Sport.

A Paper read before the Guy's Physiological Society by E. BIDDLE.

MR. CHAIRMAN AND GENTLEMEN,—The subject of my paper is one on which as yet little investigation has been done. It concerns the makers of athletic accessories, trainers, and others, more, perhaps, than our profession, but as these people have little physiological experience or knowledge on which to base their practice, they frequently go wrong. The following paper has been drawn up largely with the aid of an article by Mr. Doyne of Oxford University, and to him I am much indebted.

When one speaks of "eye" in sport one does not refer to the two organs situated on either side of the nose; they are, undoubtedly, important, but eye actually exists in the brain, and not only involves the visual sense, but is dependent on the sense of hearing, on touch, and on the accurate co-ordination of muscular movements; with these qualities a perfect eye can be worked.

Eye involves cerebral co-ordination of a very delicate character; in fact, the more delicate the degree of stimulation required to produce an effect the more proficient the eye. Bearing this in mind one realises that the visual acuity has little to do in establishing eye. One of our best-known cricket players has a visual acuity of only one-tenth of normal, and many people who have only a visual acuity of one-third of normal will declare they can see quite as well as their neighbours.

Experience teaches one to see much that the untrained eye misses. For instance, the eyesight of game-keepers, coastguards, and sailors is a gift of which we are frequently envious, but, as a matter of fact, the same quickness of vision is attainable by the majority of normal individuals if they were to undergo the same training. An interesting point is, that in a fog or dim light, short-sighted people often recognise people and animals better than a normal person can. The reason for this is that they base their knowledge on characteristic movements and outlines and not on details which are visible only in a good illumination.

A belief held by manufacturers and others connected with evolution of a shot-gun is in the importance of the "master eye," and some attempt to explain the subject of "eye" on this basis. The master eye corresponds to the right hand of right-handed persons, and is the eye we use for an operation involving the use of one eye only, such as the use of a microscope, telescope, or rifle.

We will now consider how we derive our judgment of speed and distance, as it is on the capability to obtain these judgments accurately that the good eye rests. Our judgment of distance involves the extrinsic muscles of our eyes, that is, the more our eyes have to converge on an object the nearer it is to us. We also judge distance by the apparent size of the object in relation to its surroundings. Thus, if in our field of vision there is a man and a lamp-post, and apparently the man is as tall as the post, we know that the man is considerably nearer to us than the post.

Thus, our judgment of distance depends on the muscular sensitiveness of our ocular muscles and our experience as to the size of familiar objects. It may be here mentioned that persons who have been unfortunate enough to lose the use of one eye, habitually use the focussing muscle of the sound eye instead of the extrinsic muscles of both eyes. That we use two eyes and not only the master eye for judging distance may be proved by obscuring one eye and attempting to touch an object when we find that our effort is very wide of the mark.

Our judgment of speed exists in two directions: (1) that of objects travelling towards us; (2) that of objects passing across our line of vision. The speed of those coming towards us we largely estimate by the time they take to grow apparently larger, and it was by this means that the illusion of a race between a train and a motor car, lately produced at a music-hall, was brought about. The front of the locomotive and car were—the rest of the stage being dark—represented by their headlights which were gradually enlarged and spaced further apart, so that they represented the fronts of the two vehicles growing larger. Another factor which aids us in this judgment is the time taken by the object to lessen the distance from ourselves, an observation which is well appreciated when waiting for our morning train.

Our estimate of the speed of an object travelling across the line of vision, that is, from side to side, is gained by observing the time it takes to travel past certain spaces or objects the dimensions of which we know from experience. Everyone has met with the difficulty of gauging the speed of a ship in mid-ocean, which is no doubt due to the fact that we have no surrounding objects to compare its progress with. The application of these considerations to our everyday sports is of interest and worthy of a little elaboration.

Cricket is a sport in connection with which we constantly speak of eye. Although we usually refer to the batsman, it is necessary for the bowler and fieldsmen to exercise similar judgment. Expert batsmen form an opinion as to what kind of ball they are to expect soon after it has left the bowler's hand, and thus have time to adopt the best position to deal with it. The "ball" varies in three particulars: speed, direction, and spin or break. The player judges the speed by the rate of approach of the bowler to the opposite wicket, and, as the bowler is not allowed to jerk his arm, by the speed of his hand just before he releases the ball. The pitch, that is, the spot at

which the ball will touch the ground, he localises by the moment at which the ball is released, that is, if this is early, it will be a full-pitched ball, if late, it will fall short. The direction he estimates by the position of the bowler's eyes and head, as I will explain subsequently in tennis, and partly by the path through which his hand travels before delivering the ball. The spin or twist an expert batsman can predict from the action of the hand while releasing the ball, and therein lies the success of the "googly," as with this type of ball the batsman has great difficulty in forecasting the direction of the break. The fieldsman estimates the rate of fall of a ball by judging its speed by the usual methods, although in this he is very materially helped by experience. It is generally known that a man used to catching a heavy ball, as a cricket ball, will frequently misjudge the speed when doing the same with a lighter ball, such as a celluloid one.

From my remarks on the batsman's method of predicting the variety of ball, it is easy to see what the bowler has to do. That is, to obtain direction he must fix his eyes on the wicket and attempt to hurl the ball along his line of vision; to pitch the ball he must release it at the correct moment; and to obtain spin he must cultivate the necessary manual dexterity.

To consider tennis: The receiver calculates the direction of the ball by regarding his opponent's eyes, as is well appreciated, since, when the ball travels in a direction other than that of the striker's eyes, the receiver is completely deceived. He predicts the strength of the ball by observing the force with which it is struck, that is, by the speed of the racket immediately before it hits the ball.

An interesting incident which occurs in cricket and tennis is obvious misjudgment that occasionally takes place and which is put down to the existence of a blind spot. That this blind spot has any relation to the point of entry of the optic nerve to the retina is obviously absurd, but, on first thoughts, one is rather apt to connect the two. There are two occasions when it occurs. The first is at cricket, and the following is the explanation: The batsman, as I said, has to judge the speed, direction, pitch, and spin soon after the ball has left the bowler's hand, and must at once adopt a definite position and plan of campaign in order to deal with it. If his judgment is at fault in one of these particulars he has to change his whole plan of action, and it is while his brain is in a state of flux that he has a period of mental blindness which so bewilders him that he is too late to deal with the ball.

The second occasion of its occurrence is at cricket and tennis; if a ball travels towards us along our line of vision, probably towards the root of our nose, we cannot estimate its speed by its movement in comparison with surrounding objects, and consequently for a fraction of a second or so it appears stationary; we are consequently bewildered by this apparently unnatural occurrence and are helpless, but often we realise, as the ball looms larger, that it is moving towards us, and we are enabled to appreciate the situation and cope with it.

I have previously referred to the line of vision, and as I shall use the term subsequently, I should state that by the line of vision is meant the line which meets the point, intermediate between the two eyes, at right angles, which, in plain language means the line joining the root of the nose to the object on which our gaze rests.

Before discussing the following sports—golf, billiards, and shooting—I should like to draw your notice to a phenomenon known in psychology as the attention pulse. If one gazes fixedly at an object the outlines and forms of it alternately become distinct and blurred. If one goes further and times this pulse it will be found to be about 17 per minute, or 3·5 secs. for one period of either definition or blur.

The explanation is a physiological one: The nerve cell receives by its afferent fibre impulses which accumulate in the cell, nothing is passed on to the efferent fibre until the cell was, as it were, full, and then an explosion takes place. The brain, therefore, receives a series of explosions, and between them the impression in the brain gradually fades, which accounts for the blurring of the image.

In the following sports which we will consider, the actual aim in expert players rarely exceeds 3·5 secs., and I think this is due, firstly, to the existence of the attention pulse; secondly, to the cessation of respiration causing an accumulation of CO_2 in the blood with consequent failing activity of the brain.

Billiards is a game which, above all, calls for accurate judgments. The majority of these we learn by experience, that is, estimating angles, distances, and the course which the balls take when struck and their positions when they come to rest. As regards the actual procedure of making a stroke, the following is the usual. Having estimated, by observing the position of the balls and pockets, the path his ball will have to travel to accomplish the stroke, the striker adopts a comfortable attitude for its execution. He then lowers his head so that his cue may as nearly as possible coincide with his line of vision. Having seen that his own ball will be fairly struck, he gazes along the line he wishes his ball to travel and propels his cue along the line of vision so that his ball travels in the required direction.

In all games this principle of looking at the object which one wishes to hit, and not at the hand executing the action, is most important. The hand seems to be educated to do the right action, and the more one leaves it to do its work without supervision the more are the chances of success. I may here mention, apropos of my preceding remarks, that I have never seen a good billiard player take more than 4 secs. for his actual aim.

The phrase, "keep your eye on the ball," is a

favourite with golf professionals; actually, one would find it exceedingly difficult to play without using the two eyes and not the master eye alone. A stroke in golf is made by estimating the distance of your eye from the ball and then swinging the club so as it may strike the ball fairly; but in order to estimate this distance one must use two eyes and not one.

Rifle shooting is an increasingly popular pastime, and one of the utmost use from the point of view of the State. With the usual aperture sights the visual acuity of the operator need not be necessarily high, but it is a different matter with the old V-staped sight which necessitated the shooter being able to bring the back-sight, fore-sight, and target in equally sharp focus. The point about shooting upon which stress should be laid is that of releasing the trigger, which must be done without disturbing the rifle's alignment. It is needless to state that expert shots must have perfect control over their nerves, and the duration of their aim does not exceed 4 secs. Gun shooting, as regards the question of eye, is more allied to billiards than to rifle shooting. The gun comes up to the shoulder, is pointed, but not sighted at the bird, and is then swung in the direction of the flight; the trigger release occurs soon after the gun has swung past the bird. It resembles billiards in that it feels its way into the line of vision just as a cue does, and is not sighted like a rifle.

Fencing is a sport in which the sense of feeling constitutes a large part of the "eye." Especially is this so in defence, as in attack the eye is explained in the same way as in billiards.

My paper, so far, has been solely devoted to explaining how we arrive at certain judgments in various sports, and as yet I have said nothing about the muscular reaction to these judgments. The muscular reaction is as important, if not more so, than the visual judgment, but little can be said about it. The secret of it is co-ordination. Without it the muscles move spasmodically and unevenly and waste all the fine and delicate calculations the brain has made.

The people who are placed among the large class called "duffers" largely fail on account of their inability to exercise the correct movements and not because they cannot make the necessary observations. In dancing, where no visual judgments are necessary, many people fail to execute even a comparatively simple muscular action which others do with ease.

I will not dogmatise as to the relation reflex action has with eye, but it is my opinion that few of the actions are true reflexes. Thus, a good eye depends on (*a*) normally sensitive eyes and other sense organs; (*b*) an active and capable brain to interpret and co-ordinate the sensory stimuli; (*c*) an efficient muscular system to carry out the desired action in a precise and accurate manner.

With these remarks I will finish my paper, knowing that there is much left unsaid, and many points at which you are at variance with me.

The Collection of Specimens for Bacteriological Examination.

THERE are certain deficiencies in the technique employed during the collection of specimens for bacteriological examination which experience teaches are of common occurrence. The main object of this note is to draw attention to some of these.

Distilled Water.—When a specimen of cerebro-spinal fluid, blood, pleuritic effusion, or urine is to be collected and sent to the bacteriologist it is desirable that any instruments used should not be immersed beforehand in an antiseptic lotion for fear of this coming in contact with, and so killing, any organisms in the specimen. It is equally desirable that it should not be contaminated by extraneous organisms. An antiseptic is only allowed where it will not come in contact with the material to be collected, in such operations, for instance, as the sterilisation of the skin before puncture, or the orifice of the urethra before passing a catheter. To avoid antiseptic action on the actual specimen it is customary in the wards after boiling the needle, syringe, or catheter, as the case may be, to bring it to the bedside in a dish containing distilled water. Not infrequently the specimen sent to the bacteriological department has been found to contain organisms, more especially gram negative bacilli, though there is a complete absence of pus. This fact is, in most cases, suggestive of accidental contamination. Most gram negative bacilli are morphologically indistinguishable from each other. To identify any particular kind often takes time. It is necessary to get it pure so that its cultural characteristics and sugar reactions may be noted. Purity can only be assured by planting out and picking off individual colonies for transplantation. Cultures may have to be kept for many days before a conclusion can be arrived at. A report which is required as soon as possible is delayed in consequence, and it is time wasted when it is found that the organism has no relation whatever to the case, but has been introduced by faulty technique. On repeated occasions the same gram negative bacillus has been found. It is not known to be pathogenic, and is in all probability a harmless saprophyte.

The constant recurrence of this organism in specimens of a widely different character naturally suggests a common source of contamination. In an attempt to discover this source the hospital distilled water was, among other things, examined. Samples were recently taken from half a dozen different wards and in every case this bacillus was cultivated. This shows that it is necessary when using distilled or ordinary tap water in the collection of bacteriological specimens to make sure that it is sterile beforehand. This can be done by boiling it immediately before use;

but this would not be necessary if, after it is brought to the ward from the dispensary, where no aseptic precautions are taken, the distilled water were put into flasks with proper cotton-wool plugs, the whole resterilised and kept for this purpose.

The dish for the instruments should also be rendered sterile. It is only the inside which really matters, so that one in which an antiseptic lotion has been allowed to stand for a few minutes and which is then flushed out with sterile water, will suffice.

Catheter Specimens.—It stands to reason that every avoidable source of contamination should be guarded against when collecting a catheter specimen. Particularly in females must the orifice of the urethra be seen and well cleansed with lotio hyd. perchlor. It must be admitted, however, that even when every care is taken it is not always possible to avoid a slight amount of contamination. This is due to bacteria which are often to be found in the first inch or so of the urethra. A few of these may possibly be pushed along with the catheter into the bladder and then be washed back with the outflow of urine. What generally happens, however, at any rate in the male, is that they get pushed a little higher in the urethra, and the end of the catheter, when it enters the bladder, has been wiped free of them. In the male the most common contaminating organisms are staph. albus, b. xerosis, and strept. brevis. In the female, in addition to these, b. coli is frequent.

The urine should be sent to the bacteriological department without any unnecessary delay, so as not to allow any organisms, which may happen to have crept in, time to multiply to any great extent and so vitiate the result. Warmth has a marked effect on the rate of growth, therefore this precaution applies more particularly to the summer months, but a warm room at any time of the year will naturally have the same effect.

As soon as the urine reaches the laboratory it is centrifugalised. The deposit is measured and examined microscopically and cultivations are taken. The examination of the fresh deposit is directed to determine the presence or otherwise of: (1) cellular elements; (2) tubercle bacilli; (3) gram negative and gram positive organisms and their apparent numbers.

Some bacteria, notably b. coli, may have a pathogenic significance or be simply introduced by accidental contamination; it is important to decide which. The presence of gram negative bacilli in large numbers in the *fresh* deposit is undoubted evidence of infection of the urinary tract. When pus is also present they are most probably the cause of the inflammatory process. When pus is absent the condition is one of bacilluria. When no bacilli or only an occasional one can be detected any subsequent growth of b. coli on culture media must be looked upon in the light of a contamination, and another specimen obtained.

From this point of view alone—the significance of b. coli in urine—the importance of the direct examination of the fresh deposit is obvious. This evidence is lost, and a misleading report is apt to be made if the deposit is not fresh; that is to say, if, prior to the examination of the specimen, sufficient time has been allowed for a few contaminating bacilli, under the favourable condition of warmth, to multiply and appear as a great number. If delay is unavoidable and the urine has to be kept overnight, then it must be put in a cool place. Cold does not kill bacteria; it simply arrests their growth. On the top of the incubator in the front surgery is not a proper place to leave a specimen. When the climate is cool, it may be left in the draught from an open window, but when the climate is warm it should be placed in a bowl of iced water.

Specimens of pus suspected of containing tubercle bacilli.—A swab from a discharging sinus or cavity is frequently sent with the request, "Please examine for T. B." Usually by the time it has reached the laboratory any pus that was on it has been soaked up by the cotton wool and it is in a more or less dry state. For cultural purposes a dry swab does not matter so much, but it is impossible to make direct slide-films from it, and these happen to be essential when an investigation for tubercle bacilli is required. Cultivation is absolutely necessary in the case of most bacteria before a diagnosis can be made, but for the tubercle bacillus it is an unpractical procedure, and fortunately it is not necessary. The morphological and staining characteristics of the tubercle bacillus are for all practical purposes sufficient to go upon, and so it is possible to make a positive diagnosis in a few minutes.

Cultivation is not resorted to for diagnostic purposes in the case of the tubercle bacillus, firstly, because of the time it takes to grow (it is a matter of two weeks before it shows any growth on culture media); and secondly, because even if planted it stands no chance should a more rapidly-growing organism be also present, and this is often the case in the original pus.

The only other practical method of diagnosis takes six weeks to three months. It consists in injecting a guinea-pig with the suspected material and examining it post-mortem for tuberculous lesions.

When, therefore, an investigation for the tubercle bacillus is required it is necessary to make a couple of direct films of the pus on slides at the time the pus is taken, or if there is sufficient pus to be collected in a test-tube some of this may be sent to the bacteriological department. A swab is generally useless by the time it reaches us.

Specimens for investigation of the gonococcus.—The gonococcus is a highly pathogenic and delicate organism and soon dies unless it is planted on a suitable medium. A swab which has been taken from a

case of gonorrhœa and kept for an hour or so before transplantation may sometimes fail to give a growth because the diplococcus has had time to die in the interval. The medium par excellence for cultural purposes is blood-agar. This can always be obtained when required from the bacteriological department. The gonococcus will not grow on coagulated blood serum, which is the medium distributed about the hospital, and intended particularly for the cultivation of b. diphtheriæ.

The detection of the gonococcus is often a matter of considerable difficulty. It is easily overgrown on culture media by more vigorous bacteria, and is sometimes missed in consequence. It is, therefore, advisable, when taking a swab, to lessen as far as possible the chances of contamination by other organisms. In the female this can be done by paying attention to the particular points where the gonococcus is most likely to be found and less likely to be contaminated. These are: (1) The orifices of the ducts of Bartholin and the small glands in the neighbourhood of the vestibule, which, when infected, appear as minute red spots; (2) the urethra; (3) the cervix. It should also be an *invariable* rule, when the gonococcus is suspected, never to make a culture without also making two direct films. Its appearance in pus is typical, and it is very often found by direct examination when cultivation fails.

The technique of the operation is as follows: The patient should be lying on her back with buttocks near the end of the couch and the legs flexed and separated. The labia are held well apart and the vulva is cleaned with warm water. Should the orifices of any of the glands appear red, cultures may be taken from them. Next, a swab with a narrow plug of cotton-wool on the end is selected and introduced for half an inch into the urethra. This may cause a little discomfort. A blood-agar tube is first planted and then the same swab is used to make a couple of direct smears, about the size of a sixpence, in the centre of two slides. The culture-tube should be planted before making the smears. A swab may also be taken from the vagina, but unless the discharge contains the gonococcus in quantity it is apt to be crowded out in the culture by other bacteria. A direct smear is more likely to give a positive result. Next, a vaginal speculum is inserted and is pushed up into the fornices until the cervix protrudes into it. A good view of this must be obtained, and here a head-light is of assistance.

Pressure on the speculum will dislodge any plug of mucus in the os, and a swab on a long stick, or if this is not at hand an ordinary swab grasped at its end in Spencer-Wells forceps is then inserted into the os. Care must be taken that it does not come in contact with any other part but the os, and if there is a lot of discharge coating the cervix, this should be wiped away beforehand with cotton-wool wrung out in warm water and introduced on long forceps. A blood-agar culture and direct smears are then made as before.

The gonococcus may be found in all four situations —the orifices of the various glands, the urethra, the vagina, and the cervix. Frequently, however, it is only found lurking in the urethra or cervix.

In the case of children, swabs should first be taken from the vagina and vulva. The vulva is then cleansed and a urethral specimen obtained.

In the male, if a meatal swab proves negative, a deep urethral specimen should be taken by means of a three inch urethral speculum and a platinum eyelet.

H. C. LUCEY.

Pupils' Physical Society.

A Pathological Meeting of the Society was held in the Wills Library on Saturday, January 10th, Mr. W. E. Tanner in the chair.

Mr. S. Keith gave a demonstration of spirochætes as seen motile by dark-ground illumination and by the Indian ink method. Mr. Keith is to be congratulated on a most successful and interesting demonstration, which was very greatly appreciated by the comparatively few men who turned up to the meeting.

The following gentlemen showed and described specimens:—

Mr. E. J. Cooke: Blood-film from a case of acute spleno-medullary leukæmia. Ulcerative endocarditis of the aortic valve.

Mr. C. W. Baxter: Lardaceous disease of spleen, kidney, liver, suprarenals, and thyroid gland, from a case of chronic suppuration.

Mr. T. P. Cole: Chronic gastric ulcer.

Mr. K. L. Bates: Intussusception, with gangrene and thrombosis, following four days after operation.

Mr. E. W. Blake: Pontine hæmorrhage, from a case of granular kidney.

Pathological Meetings of the Society are always less well attended than others, especially by the Resident Staff of the Hospital, who possibly feel that now their examinations are over they can afford to let a dull subject slide. But, as the pressure of clinical interests compels us to discard one of the sciences, that we have so laboriously studied, after another, it is most important to retain a familiarity with, and an interest in, pathology to the last; without it every diagnosis is a shot in the dark, every treatment empirical. General practice differs from hospital practice in nothing more than in the neglect of pathology, and no one need have any fear of getting rusty who maintains his pathological interests.

These Physical Society Meetings, dull as they may be, form the only opportunity we have of discussing pathological questions, and it is the greatest possible pity that more general interest is not taken in them. Moreover, the greater the number of men who come and show specimens and talk about them, the more interesting, the less dull, they will become. "Dare quam accipere" is a maxim of profound scientific truth, for the Physical Society and each one of its individual members.

Ralph Wingent Memorial Fund.

FIRST LIST OF SUBSCRIPTIONS.

	£	s.	d.
"Residents in College," per John Ryle ...	1	5	0
A. Neville Cox, Brighton	0	2	6
H. Nisbet Eccles	0	2	6
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William Wale, Wills Library	1	1	0
	£5	3	0

January 14th, 1914.

H. C. MANN,
P. S. PRICE,
Hon. Secs.

Papers by Guy's Men.

L. A. Parry, B.S., F.R.C.S.: Acute Intestinal Obstruction in Children.—*Clinical Journal*, January 14, 1914.

P. Turner, M.S., F.R.C.S., and H. Tipping, M.D.: Case of Mesenteric Cyst simulating an Intussusception.—Proc. Roy. Soc. Med., December, 1913, Sect. Study Dis. Child., 29.

A. F. Hertz, M.D., and W. Johnson, M.D.: Case of Myatonia Congenita.—*Ibid.*, Clin. Sect., 30.

A. F. Hertz, M.D., and W. Johnson, M.D.: Case of Cervical Rib with marked Vascular Symptoms.—*Ibid.*, 32.

E. G. Graham Little, M.D.: Case of Syphilis of Very Unusual Character.—*Ibid.*, Dermat. Sect., 44.

W. M. Mollison, M.C., F.R.C.S.: Case of Epithelioma of the Floor of the Mouth and Tongue.—*Ibid.*, Laryngol. Sect., 12.

P. Turner, M.S., F.R.C.S., and W. M. Mollison, M.C., F.R.C.S.: Case of Pneumococcal Infection of the Pharynx and Larynx.—*Ibid.*, *Ibid.*, 13.

T. B. Layton, M.S., F.R.C.S.: Mass attached to Laryngeal Wall.—*Ibid.*, 16.

G. Newton Pitt, M.D.: Recurrent Distension of the Parotid due to calcification round a Fish-bone.—*Ibid.*, Medical Sect., 36.

E. P. Minett, M.D.: The Pathogenicity of the Organisms Isolated from Non-ulcerating Cancerous Growths.—*Ibid.*, Pathol. Sect., 36.

W. Sampson Handley, M.S., F.R.C.S.: A New Method of Administering Saline after Abdomino-Perineal Excision of the Rectum.—*Ibid.*, Sur. Sec., 74.

Major C. E. Pollock, R.A.M.C.: A Comparison of Foreign Army Medical Methods with those of the British Army, with Special Reference to the Territorial Force.—*Journ. Roy. Army Med. Corps*, Jan., 1914.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Gazette Special Pathologist.

H. L., MANCHESTER.—This is a carcinoma of the skin of the rodent ulcer type. It is composed of branching epithelial ingrowths derived from the deepest layer of the epidermis, and is infiltrating the subcutaneous tissues. PATHOLOGIST.

Rugby Football.

GUY'S v. BLACKHEATH.

For this match at Blackheath, on Saturday, January 10th, Guy's tried a new formation—Millett and Medlock filling the inside positions and Davies playing at the scrum base. The new arrangement, although strongly advocated by the writer, was not very successful, but it is only by experiment these things can be proved. Blackheath beat us by 2 goals and 4 tries, 22 points, to nothing, and for some time had only 13 or 14 men. True, we had not played for some time, but this must not be made too much of. The truth was the Blackheath back division were too good for us. They ran very fast and passed well. Our forwards played a hard robust game and got the ball frequently, but there the story ends; our attack never developed scientifically or looked really like opening up a chance for either wing.

De Villiers was a scorer almost from the kick-off. Then Cook was tackled when very dangerous. The Hospital got going, but just when Medlock appeared to have a chance he slipped up. De Villiers and Coverdale after good play were the next try getters for the Heathens, and Hughes also put on another; one being converted, the Heathens were 14 points to the good at half-time.

Blackheath at this time had only 13 men, but Hughes soon resumed, and then Horan, the Blackheath half, broke his arm and otherwise hurt himself, so he had to be carried off. Although short, Blackheath finished well, King and De Villiers getting further tries, one of which Coverdale added the extra points to.

GUY'S.—A. H. Harkness (back); S. S. L. Steyn, C. H. Medlock, H. Millett, A. F. Rook (three-quarters); L. R. Broster, J. E. Davies (halves); C. S. L. Roberts, O. Parry-Jones, A. S. Liebson, A. B. Danby, M. Tweed, G. F. Kidman, C. H. Laver, E. F. Llarena (forwards).

PERIODICALS RECEIVED.—Middlesex Hospital Journal, Birmingham Medical Review, St. George's Hospital Gazette, The Prescriber, Journal of Clinical Research, St. Bartholomew's Hospital Journal, Polyclinic, Clinical Journal, Hospital, Nursing Times, London Hospital Gazette, University College Hospital Magazine.

Birth.

MOYLE.—On December 30th, 1913, at Henstridge House, Henstridge, Somerset, the wife of Henley H. Moyle, of a son.

Death.

HARSANT.—J. G. Harsant, M.D., The Hive, Exeter Road, Bournemouth, at the age of 52.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 668.] JANUARY 31, 1914. [SIXPENCE.

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Passim.

WE gave in our last issue a brief account of the origin of the B.N.A., and indicated the present position of affairs and how it was brought about. To recapitulate: at the present moment the B.N.A. is not officially recognized by any of the examining bodies in London, nor by the Anatomical Society—the latter body has, if our information is correct, determined to prepare a revised terminology for presentation to the next International Anatomical Congress in 1915—but nevertheless it has found favour with the Edinburgh Schools and also with some teachers in America and the Colonies. Thus far there is no urgency—indeed from the point of view of the ordinary man no importance and no interest in the matter.

But the controversy has become interesting and important to both students and teachers, alike of anatomy and surgery, during the past twelve months, because nearly all the text-books of anatomy and operative surgery which have been published or revised in that time have adopted the new terminology. We have in the Gazette Office received a large number of anatomical works for review during the past nine months, and only two of these—neither of which in any way aspires to take the place of a text-book—have remained true to the old names.

WHAT, then, is the student to do? The first question he asks is, naturally, "Will the examiners expect me to know the new or the old terminology?" From his point of view that is the crux of the whole matter. He is not an anatomist; almost certainly nothing is farther from his mind than any desire to become one, and is only concerned with it as a necessary preliminary to his serious work on the clinical side. We have no official knowledge upon the subject, but it seems clear to us that, in the present uncertain condition of affairs, the examiners are morally bound to accept whichever terminology the candidate offers them. Indeed, in the recent Primary Examination for the Fellowship the examiners made it clear that this was their own view when they printed in brackets after *serratus magnus* its B.N.A. equivalent *serratus anterior*. Therefore, as regards this aspect of the case, we do not believe it matters in the least which nomenclature the men in the dissecting-room use.

THERE is, however, another point of view from which this matter is important to men both in the wards and in the dissecting room. Anatomical terms are not confined to anatomical text-books—they abound in all works on both medicine and surgery, and changes introduced in the dissecting room will, in course of a few years, find their way into the medical books. So that, if the B.N.A. has come to stay, there will shortly be many terms in the text-books unintelligible to the man who finished his anatomy before the arrival of the B.N.A. This will be sufficiently confusing for a few

years, but we are promised or threatened with yet another group of names which will put us all out-of-date. So that in reality it does not at present signify which we know, except that the new official terminology will almost certainly more nearly resemble the B.N.A. than our present nomenclature. Because in our opinion, and as far as we can gather in the opinion of a large number of others, the B.N.A. is in very many particulars superior to the current terms. The opponents of the new names are accustomed to rake up some dozen absurdities among the new terms, produce them in a bunch (it is always the same bunch), and then wash their hands of the whole matter. More careful scrutiny of the whole terminology, more especially from the point of view of its descriptive advantages to a man coming fresh to anatomy, would, we believe, induce many of them to modify their views on the matter.

IN his will the late Mr. J. H. Targett very generously left to the Medical School a sum sufficient to bring in approximately £300 a year which is to be devoted to the upkeep of the new Pathological Department. This bequest adds yet another to a long list of gifts to the department by generous friends of the School. It will be remembered that when the Department was built and equipped at a cost of more than £13,000 an anonymous donor came forward and very generously defrayed the whole cost of the building and its equipment. Further from other sources the School has been fortunate enough to receive endowments sufficient to cover two-thirds of the sum (£1,400) expended annually on Lecturers and Demonstrators.

IT is hoped that the time will soon come when the whole Department—which is, we believe, unique of its kind in London, performing as it does no part of the ordinary routine work of the Hospital, devoting itself entirely to teaching and to the investigation of disease—will be staffed, equipped, and maintained by endowment provided for the purpose. Freed from the necessity of maintaining this Department, the other resources of the School would then be available for the more elaborate equipment of research even more directly in association with the work in the Wards.

THE Hospital has recently been the recipient of a gift, the circumstances attending which must, we believe, be almost unique. It took the form of £500 for the endowment of a cot, and came from Mrs. Henderson, of Beckenham, Kent. The whole of this substantial sum has, we understand, been earned entirely by Mrs. Henderson's skill with her fingers in doing fancy work. She has been continuously engaged upon this project, making and selling her work for the past fifteen years, and has quite recently attained the desired sum to endow a oot. The energy and patience which Mrs. Henderson has displayed, the disappointments and discouragements she must have surmounted, are sufficient to astound one. Had the sum saved been a very small one, all interested in the Hospital would have been very grateful to Mrs. Henderson for all her work, but when so, comparatively speaking, large a sum is forthcoming our gratitude is trebled. We would like to say to others "Go and do likewise," but we know that there are very few who would give so much time and trouble. The very best thanks of all who are interested in Guy's are due and are forthcoming to Mrs. Henderson.

THE Physical Society announce for their next meeting an address on "Homœopathy," by Dr. C. E. Wheeler which should be exceptionally interesting. Dr. Wheeler is Physician to, and Lecturer on Materia Medica at, the London Homœopathic Hospital, and is therefore well qualified to expound the views of Hahnemann, the founder of the Homœopathic School. Most of us know nothing at all of homœopathy; we have a vague idea that its main principle is to give infinitesimal doses of drugs, and to direct attention not to causes but to symptoms. Whatever be the rights or wrongs of the controversy between the allopaths and the homœopaths it is clear that there must be some truths on each side. No schismatic or heretic ever maintained for any length of time a wholly false position, and therefore it behoves any man who takes an

intelligent interest in his work to seize this opportunity of hearing the other side and attempting to judge for himself. The meeting will be held in the College Smoking Room on Thursday, February 5th, at 8.15 p.m.

THE Guy's Hospital London University Club are holding their Annual Dinner on Friday, February 20th, at 7.15 p.m., at Pagani's Restaurant. The price of the dinner has been reduced to four shillings, and it is hoped that this reduction will tempt a far larger number of men to put in an appearance this year. The dinner could be made one of the best functions of the year if only the members would display a little more enthusiasm. There are large numbers of London University men around London who could easily attend with a small effort. We can promise them a very enjoyable time if they will turn up. All men taking the London University course, whether qualified or not, are eligible for membership, which entails no liability.

THE results of the recent examinations are very good indeed and are well worthy of comment. In the First Conjoint the results were especially good. In Chemistry 11 out of 17 passed, in Physics 15 out of 16, and in Biology 4 out of 6. In the First M.B. (London), 10 men completed the examination and 7 failed in one or more subjects. We congratulate both the successful men and their teachers.

MRS. GALABIN has recently very kindly presented the Governors of the Hospital with a very fine portrait of the late Dr. Galabin in Academic robes. The painting, which is an excellent character study of Dr. Galabin, has been hung at the foot of the Court Room staircase, in series with the other portraits of our distinguished past men.

WE notice with pleasure that Mr. A. H. Tubby has been elected a corresponding member of the Société Française de Chirurgie.

The Acute Pellagra Case.

(Continued.)

IN completing this report upon this case, I should like to mention that on November 8th, 1913, the "aspergillus" organism was found by Dr. Slade, the bacteriologist and pathologist.

Causes of Pellagra—

Ceni believes the aspergillus is the cause.

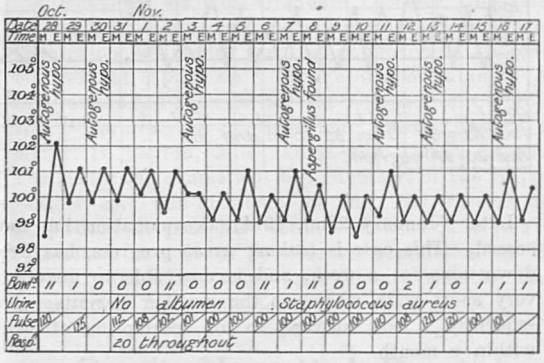
Tizzoni ascribes it to a pleomorphic streptobacillus pelagræ, perhaps an actinomyces.

Sambon concludes that maize has nothing to do with pellagra, but that it is due to the similmur fly.

Perroncito submits that maize is a diet which enfeebles and leads to poverty of the system and that there can be no doubt of the toxicity of spoilt maize.

Allesandrini says that pellagra is due to an infecting agent in the water.

Long attributes pellagra to an infection of the intestines by an amœba.



According to Ceni, then, aspergillus *is the cause* of pellagra, thus proving conclusively that the "dermatitis exfoliativa" was *not* the cause of the disease, but merely a symptom.

The patient is now able to sit up for some hours daily in a chair, and to walk a few steps holding on to the bedstead. Although emaciated, his muscles are improving.

On December 9th Dr. Slade inoculated an animal with pus preparation from the patient for further investigation.

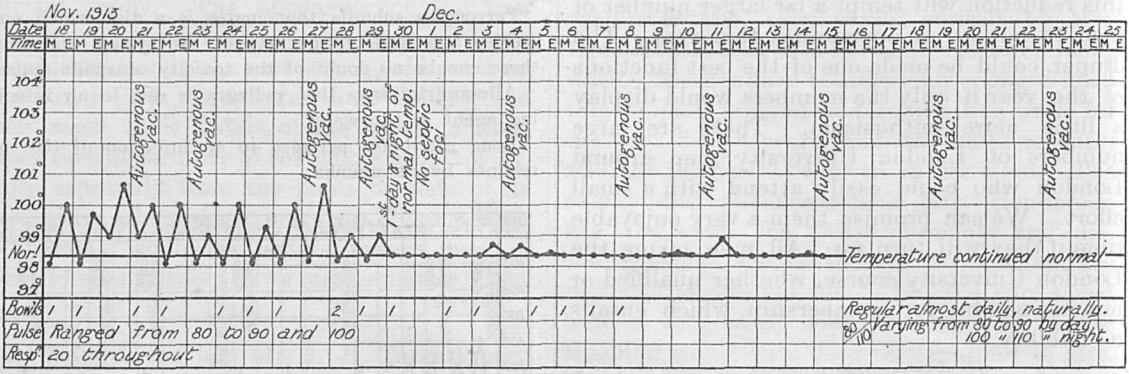
After 80 *days* of high temperature and suppuration these symptoms ceased. I attribute the recovery of this patient to his ability to take plenty of food and also assimilate it; doubtless the half to one ounce of blood with wine, same quantity, every four hours at first, and up to date twice daily, with extremely strong meat and chicken essence (home made), also beef, mutton, fowl, fish, bacon, and cream and milk, tea and cocoa kept him going and free from anæmia.

Inunction of cod liver oil after the cessation of sepsis materially benefited the skin by feeding it and

diminishing the desquamation. Later on, massage with the oil improved the tone of the muscles very considerably. Ichthyol and quinine contributed, together with the autogenous vaccines, to abate the septic condition, and prevented him from succumbing to the pyæmia. The desquamation, although not completely quelled, is only slightly perceptible upon the arms and hands.

The *knee reflexes*—right slightly affirmative; left, negative.

To conclude, this case is most hopeful, and I think illustrates the old axioms, "nil desperandum," and "quantum mutatus ab illo."



Later (January 22nd, 1914), desquamation has now ceased. This case is making great progress, has been downstairs for a week, and is now able to go out a very short walk whenever the weather permits; consequently I look forward to his resumption of work within a month.

W. H. SPURGIN.

Newcastle-on-Tyne.
January 22nd, 1914.

P.S.—The first instalment of this case was published November 8th, 1913, in the GUY'S HOSPITAL GAZETTE.

Change of Address.

Dr. R. A. Chisolm, to 37, Queen Anne Street, W. (Telephone, Battersea 311 and Mayfair 2029.)

A. H. Forbes, L.D.S., from 65, St. John's Terrace, Hove, to 22, Old Park Villas, Palmer's Green, N.

Percy H. Hickman, L.D.S., from 68, High Street, Ramsgate, to 6, Nelson Crescent, Ramsgate.

D. A. Mitchell, M.B., B.S., R.N., from H.M.S. *Alert*, East Indies Station, to c/o "St. Andrew's," Westcombe Park Road, Blackheath, S.E.

Dr. N. Mutch, from 8 to 26, St. Thomas's Street, S.E. (Telephone, Hop 60.)

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

Civil.

G. R. Hind, M.B., B.S., has been appointed Honorary Surgeon to the Cottage Hospital, Longton.

F. Douglas Turner, M.B., Medical Superintendent of the Royal Eastern Counties' Institution for Imbeciles and the Feeble-minded, Colchester.

Naval.

Staff-Surgeon A. R. Thomas to the *President*, additional, for the *Maine*.

Surgeon G. Carlisle to the *Victory*, additional, fo Haslar Hospital.

Surgeon A. M. Henry to the *Minotaur*.

Notice.

Royal Naval Medical Service.

The next Examination of Candidates for the Royal Naval Medical Service will be held at Examination Hall, 8–11, Queen Square, Bloomsbury, W.C., on the 30th March next and following days. The number of appointments to be offered for competition is 25. The Regulations for Entry and the form to be filled up by Candidates will be supplied on application to the Medical Director-General, Admiralty, London, S.W. The form accompanied by the necessary documents should be returned not later than the 19th March, 1914. Candidates must not be under 21 nor over 28 years of age on the day of the commencement of the Competitive Examination, and must be registered under the Medical Act in force, as qualified to practise Medicine and Surgery in Great Britain and Ireland.

The Examination will consist of:—A. Medicine, including Medical Pathology and Therapeutics. B. Surgery, including Surgical Pathology and Clinical Surgery.

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Nursing News.

MATRON'S OFFICE.

On January 1st, 1914, Nurse Groom, Nurse Payne, and Nurse Foord-Kelcey left the Hospital on completion of their three years' training. Probationer Marfleet was appointed to succeed Nurse Groom in Bright ward; Probationer MacMahon, Nurse Payne in Martha ward; and Probationer Apfel, Nurse Foord-Kelcey in Esther ward.

On January 1st, Nurse McComas was transferred to the Theatres, and Probationer Brennand succeeded her as Head Nurse in John ward.

On January 3rd, Nurse Poole, Head Nurse in Queen, left the Hospital on completion of her three years' training; Nurse Hiles, Head Nurse in the Surgery, was transferred to Queen ward, and Probationer Bowdler was appointed Head Nurse in the Surgery.

On January 3rd, Nurse Foxon, Head Nurse in the Out-Patient Department, left the Hospital on completion of her three years' training, and Probationer Steward succeeded her as Head Nurse in the Out-Patient Department.

On January 6th, Nurse Macdonald, Head Nurse in Job ward, left the Hospital on completion of her three years' training, and Probationer G. Osborne was appointed to succeed her.

On January 12th, Nurse Garvin, Head Nurse in the Eye wards, left the Hospital on completion of her three years' training, and Probationer Looker was appointed to succeed her.

On January 16th, Nurse E. de V. Fletcher, Head Nurse in Lydia, and Nurse Tyers, Head Nurse in Addison, left the Hospital on completion of their three years' training. Probationer Staines was appointed Head Nurse in Lydia, and Probationer M. A. Jones, Head Nurse in Addison ward.

On January 19th, Nurse C. Pearson, Head Nurse in the Out-Patient Department, left the Hospital on completion of her three years' training, and Probationer E. Cox was appointed to succeed her.

On January 20th, Nurse W. Warner, Head Nurse in Queen ward, left the Hospital on completion of her three years' training, and Probationer M. B. West was appointed to succeed her.

On January 21st, Nurse McComas and Nurse E. V. Smith left the Hospital on completion of their three years' training. Probationer Gilchrist was appointed to succeed Nurse McComas as Head Nurse in the Theatres, and Probationer Rollo, Nurse Smith, in Charity ward.

On January 23rd, Probationer A. M. McKitrick was appointed Head Nurse in the Eye wards.

The following Probationers were successful in passing the Probationers' Examination in Medicine held in December:—

First Class:—Probationers Bristow, Broadwell, Crisford, Cuthbert, Dixon, Doig, Foskett, Freshney, Galavan, Gould, Grundy, Hampson, M. K. Hayne, Hook, E. V. Jordan, King, Little, A. S. McKitrick, O'Gorman, Opie, Pilkington, Rennie, Rowe, Sanford, Shepherd, Sherrin, E. A. Smith, S. Ward, Webster, and Whitworth.

Second Class:—Probationers E. Bollard, J. Browne, Browning, Casson, Cockshott, D. Cox, Croasdaile, De Saram, Dingle, B. Edwards, F. Edwardes, Fletcher, Franklin, Gregg, Hogan, Hopkins, W. Jones, M. Jordan, Kerfoot, Ledlie, Loughnan, Marshall, Messenger, Mitchell, Moir, Morell, Morris, Passmore, Phillips, Plant, Price, Rees, D. Rice, M. Rice, Roscoe, Shorter, P. Smith, Speller, Spouncer, Thackray, Thomson, Tovey, van Weddingen, F. Ward, Warner, and West.

A course of six Post-Graduate Lectures, illustrated by the Epidiascope, will be given in the Pathological Theatre on Wednesday evenings commencing February 4th next, at 8 p.m., on "The Feeding of Infants," by Dr. Cameron, Physician for the Diseases of Children, and "The Nursing of Nose and Throat Cases," by Mr. T. B. Layton, M.S., Aural and Throat Surgeon. The fee for the course will be: Members of the Nurses' League, 5s.; non-members, 7s. 6d. The lectures will be printed in pamphlet form, and sent post free to subscribers as soon as possible on completion of the course. Intending subscribers should send in their names to the Matron at once.

Guy's Hospital Dental Society.

A Meeting of the above Society took place in Class Room No. 1, on Friday, January 16th, the President being in the Chair. Casual communications were brought forward by Messrs. Clewer and Viljoen.

Mr. Crook then read his paper entitled, the "Advantages and Disadvantages of Hospital Pupilage." This paper was the outcome of a remark in the inaugural speech of the President at the commencement of the session, in which he said he hoped that a paper would be read by one of the pupils. The paper was, we believe, Mr. Crook's maiden effort, and he is to be complimented on the good show he made.

The subject he took for his paper was certainly no new one, but he managed to put quite a new vitality into what could easily have been a dismal and uninteresting debate. There seemed no doubt in Mr. Crook's mind about the great advantage of Hospital Pupilage, and, as he candidly confessed, he found it difficult to state the merits of both sides of the question.

He grew really eloquent over the advantages of Hospital training, but was rather non-plussed to find any real advantages occurring from doing pupilage outside. The paper was very controversial in nature, and, as was expected, brought a good many members forward to display their talent—or otherwise.

The President opened the discussion with a really excellent speech, and this was followed in quick succession by members red hot to talk about something, however irrelevant. We should argue from one member's remarks that he is more in the habit of frequenting the restaurants in the vicinity than the Mechanical Laboratory or Conservation Room. The result of the discussion was, that most members thought that a combination of Hospital and Private Pupilage was really the most efficient way of doing things, and the meeting closed, leaving everyone quite pleased with themselves and the debate.

DENTAL CORRESPONDENT.

Obituary.

JOSEPH GEORGE HARSANT.

WE regret to record the death of J. G. Harsant, who was a well known and popular Guy's man in the early eighties. Born in 1861, he was educated at Epsom College where he passed his London Matriculation and Preliminary Scientific Examinations. He entered Guy's in 1880, and took the M.B., B.S. Lond. in 1885, and the M.D. in 1887. Having held the posts of R.O. and H.S. at Guy's, he was appointed Resident Officer to the City of London Hospital for Diseases of Chest, and at the end of that time he acted for three years as medical officer in the service of the P. &. O. Company. He finally settled in practice at Bournemouth in 1892, and he there succeeded in building up an extensive practice. He was very musical and possessed a good baritone voice, which in his younger days made him very popular in society. He was a useful cricketer and played cricket with the Bournemouth cricket club, but latterly he gave up cricket for golf and became quite a good golf player.

Not long after settling in Bournemouth he was appointed on the assistant staff of the Royal Victoria Hospital, but when a vacancy arose on the full staff he found it was necessary to hold the qualification of M.R.C.P., so he gave up several months entirely to study, went back to Guy's and succeeded in passing in 1905. He was elected full physician to the Victoria Hospital in 1905, and physician to the Royal National Sanatorium for Consumption in 1908, since which he did a fair amount of consulting practice as well as a large and lucrative private practice.

He died after a painful illness on January 9th, at the comparatively early age of 52. He was never married, but few had more intimate friends than he had, while it may be truly said that he never had an enemy.

Notices.

Guy's Hospital London University Club.

The Annual Dinner will be held on Friday, February 20th, at 7.30 o'clock, at the Restaurant Pagani, 44, Great Portland Street, W. The President, Dr. John Fawcett, will take the Chair. Dinner (exclusive of wine), 4/- each.

The Annual General Meeting will be held at 7.15 p.m., on February 20th, before the Dinner. AGENDA: i—Minutes of the last Meeting. ii.—The proposal for election, on the nomination of the Committee, of the following Officers for the year 1914:—President—Dr. John Fawcett. Vice-Presidents—Dr. J. A. P. Price and Mr. F. J. Steward. Hon. Secs.—Dr. C. E. Iredell and Mr. W. E. Tanner. Committee—Mr. F. Durham, Dr. D. Forsyth, Dr. T. D. Lister, Mr. C. S. Lane-Roberts, Mr. T. B. Layton, Mr. G. E. Kidman, Mr. R. J. Reynolds, Mr. G. Marshall, Mr. G. T. Mullally, Mr. F. A. Knott, Mr. Sampson-Handley, Mr. M. B. M. Tweed.

C. E. IREDELL,
W. E. TANNER, } Hon. Secs.

Royal College of Physicians of London.

CHARLES MURCHISON SCHOLARSHIP IN CLINICAL MEDICINE.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 15th day of June, 1914, and following days. The Examination is open to any Student of Medicine who, subsequently to the date of passing his professional Examination in Anatomy and Physiology for a medical qualification, has studied for a period of not less than two and a half, and not more than five, years at a Medical School in London, recognized by the Royal College of Physicians, or at the University of Edinburgh, including Medical Classes recognized by the Medical Faculty of the University, whether holding a Medical qualification or not.

The Examination will be conducted both orally and in writing, and will include—(*a*) Examination of Patients, with reports on their cases. (*b*) Questions on Pathology and Treatment, and (*c*) Examination on Specimens. The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than June 1st, with evidence of the duration of their Medical Studies from the Deans of their respective Schools, and evidence of the date at which they passed their Examination in Anatomy and Physiology. (The Examination for 1915 will be held in the University of Edinburgh.)

Pall Mall East, S.W., January, 1914. J. A. ORMEROD, M.D., Registrar.

The Debating Society.

Ladies' Night.

JOHNSON is credited with embellishing some of the finest perorations of the Great Commoner. If we are guilty of bathos, we bid you remember that history repeats itself. It is extraordinarily difficult at the best of times to report accurately the utterances of even a logical and coherent speaker. So often the personality of the man overshadows his finest argument, that one seeks vainly *for the latter long after the culmination of the speech.* Other speakers there are—and these try not only the writer, but the chairman also—who figuratively spin a rope of irresistances and anticlimaxes wherewith to hang themselves in the course of time.

There are others who are debaters pure and simple. These are the kings of speakers; for a debater is one who relies on the opportunities which wiseacres afford. His keen wit is so nimble, his reason so subtle, his side play so unconscious, yet so effective, that out of one tiny discrepancy in an opponent's speech, he is able to weave as it were a series of bantering phrases, innumerable witticisms, to make a point or a thrust, to parry a blow, so that it falls on the striker with all the skill and finesse of a practised fencer.

To the latter we cannot hope to do justice. Such irony, sarcasm, humour, and splendid invective is altogether inanimate apart from the speaker. To chronicle a jest in cold merciless ink is to destroy the point and to hold its author up to the ridicule of the uninitiated. The former we may reasonably hope, with the exercise of a little discrimination, successfully to report, for many would blush to see their own verbatim speeches. In such cases the Editor is given a free vein. He may, after the manner of Johnson, prune and embellish to his heart's desire, so that men will smile and grow immeasurably in their own estimation when they read their own wise and eloquent sayings in the charitable columns of the GAZETTE.

Ladies' Night! Advertised, talked about, worked *upon, cherished with thought and nurtured with care.* How easily one could "point a moral and adorn a tale."

Once a year the Society throws open its doors; the unruly utterances of its members are hushed. It puts on its best garb; the fire is banked up; the committee honour it with its presence; the president comes to grace the proceedings with his kindly tact and dignified impartiality. For one night in the year the Society comes into its own. And what of the guests? Each year they come; each year, too, we fear, they go away just very slightly disappointed. Yet in a measure our visitors contribute unconsciously to their own passing dissatisfaction.

Ladies' Night is somewhat of a misnomer. Literally it means a debate in which ladies are *par excellence* the speakers of the evening. *It is intended that they* should contribute, too—nay, provide the bill of fare; and in so far as ladies speak or remain silent depends the success or failure of the debate. This, of course, is not strictly true, but nothing in these accounts is absolutely correct, yet in another sense the statement is not grossly inexact.

Few men are good speakers, and their natural reticence, modesty—call it what you will—is increased immeasurably by the presence of attentive visitors. A man who at an ordinary discussion does not hesitate to indict his neighbours, who has no scruples in calling his opponent a consequential blitherer, often finds his vocabulary painfully restricted in a mixed audience. Thus the Society is at the same time at its best and at its worst. It is only fair to say that some of the visitors did their part honourably and well, but others there were who, not knowing whether to be serious or gay, chose the easier way, and remained immovably silent.

During the past five years that we have known the Society we have watched the career of Mr. Layton as a speechmaker with unfailing interest. We remember well when he was jerky and somewhat unconvincing. Each year, if we may say so, he has improved immensely, till now he is counted as one of the best speakers in the Society. To talk for twenty-five minutes without a note, absolutely off the point (with due respect to the Chairman) with undiminished humour and with a quaint air of detachment, is a feat which few of us can hope to rival. At once dominating and appealing, versatile and intensely vivacious, never at a loss for a word, yet always Layton. We havn't the remotest idea what it was all about—sundry epigrams about socks, foul pipes, and pity remain with us as gems of polite yet vibrant English, but for the rest——. Think of a Welshman's imagination, an American's humour, an Irishman's logic, and you have the speech far better than we can reproduce it.

Mr. FITZGERALD, in a maiden speech, showed himself to be a distinct acquisition to the Society, but he would do well to burn every note he ever makes. The first part of his speech, which was quite impromptu, was really excellent, subsequently it became somewhat prosy.

Mr. HEATH succeeded in being intensely human, and *exceedingly facetious. We are inclined to think it* marks his best effort of the year. It requires not a little skill to tell a story against oneself, which is at the same time both true and genuinely amusing. We think he must have heard of Helen Mar's query to an American friend—

"Say, Have you heard my last story?"

"I hope so."

We are glad that he has lost the Johnson touch: perhaps he is reverting to the Scotchman, after all.

We cannot attempt to describe the speech that followed. Mr. MARSHALL is too well known as a keen wit to need anything that we can write to keep up his reputation. He fell foul of Mr. Schlesinger, who was as truculent as of old.

Various speakers continued the discussion. Some emerged from the gloom in the far corner of the room,

and attacked Mr. Layton under the protection of the House—*Gare à vous*, we would warn them; others told us they were married, and then in the same breath inferred they were bachelors, whereon a lady interposed in a humorous speech.

The Hon. Secretary of the Royal Free was very fluent, and spoke to the point, one of the few speakers who did so. We should have liked a twenty-minute speech, and hope another year to be fortunate enough to be present to hear it.

Subsequently the debate became rather ragged. Mr. Sampson, from whom we expected much, was not in form. Mr. Sherries spoke of the inside workings of the College, deplored that he could not sew, longed for the day when he could get married, and generally spoke to the point and well. Other speakers will forgive us if this account is already too long to include their views. We must not omit, however, Sister Cornelius, whom we would like to hear as often as there is a pause in the discussion.

We were pleased to see among the visitors the "Matron," who seldom fails to support the Society on these occasions, while the thanks of the members are due to Dr. Lauriston Shaw for his unfailing attention on Ladies' Night.

Some 115 members were present. The motion, which we forgot to state, was that "A Tax should be placed on Bachelors," was ignominiously defeated by a large majority.

Guy's Hospital Physiological Society.

The Annual Dinner of the Physiological Society was held on Thursday, January 15th, That the Dinner was a record in every respect will be agreed to by all who were in possession of their faculties at the end of the evening. After an excellent dinner, and the toast to the King, Mr. Thomson proposed the health of the Chairman in a few chosen words. After flattering himself by a comparison with Joseph, he presented to the Society a new Physiological Table for the measuring of mental stability. The principal measures were 1 tanner, 1 leviseur, 1 trail, and 1 fitzgerald. The Chairman, in his reply, was quite himself in acknowledging the merits of the different demonstrators in his department; not only did these gentlemen smooth the various difficulties the Chairman encountered in the wards, but they succeeded in persuading the members of the Society of the grave nature of Physiology, a task the Chairman had long ago given up as hopeless. The health of the Anatomists was then proposed by Mr. Marshall, who showed an astounding knowledge of the new terminology. He severely rebuked the anatomists for being solely concerned with the carcass. In spite of elaborate preparations Mr. Mullally, in replying to the last toast, spoke of facts that weren't facts, and it was obvious that the Physiologists were enjoying a walk over at this stage. Their position was strengthened by the speeches of Drs. Kennaway and Ryffel, which were the most appreciated of the evening on account of being physiologically correct. The Ferhz-i-hologists turned pale as Mr. Layton commenced to dissect them at this stage, and by this means retrieved the lost position of the Anatomists—and all this, though Mr. Layton had prepared himself to praise and not to bury the Ferhz-i-hologists. He pointed out the relations of the Ferhz-i-hologists to the Chemists and Physicists, and accused the former as being the results of dissecting the latter. His remarks on the Physiologist of the Hospital were unduly severe, Mr. Layton evidently forgetting the excellence of that gentleman in the dissecting room. The health of the visitors was proposed by Mr. Fitzgerald, and never did that gentleman give a more thorough display of his oratory. In his Physiological views he was undoubtedly Pembritic, and announced that he would allow the Chairman to share the joys of the proudest moment of his life. Mr. Merriman then replied in the most co-ordinated manner. He laid stress on the wonderful metamorphosis caused by the Society on certain spoon-fed individuals who were, in addition, chemically unsound. The music of the evening was rendered by Messrs. Thomson, Harrington, Ryffel, and Rogerson, and the success of the Dinner was in a large measure due to these gentlemen. After demonstrations of strength by the heads of the various departments, a most enjoyable evening ended.

Papers by Guy's Men.

H. Chapple, M.C., F.R.C.S.: Some effects of chronic intestinal stasis on the female generative organs.—*British Medical Journal*, January 24th, 1914.

J. Howell, M.B., B.S., F.R.C.S.: Mistakes in the diagnosis of perforated gastric ulcer.—*Clinical Journal*, January 7th, 1914.

E. P. Poulton, D.M., and another: The alleged excretion of creatine in carbohydrate starvation.—Proc. Roy. Soc., Ser. B, 87, 1914, 205.

E. P. Minett, M.D., D.P.H., D.T.M. & H., and Govt. M.O.H. and Bacteriologist, British Guiana:—

A review of the Cause of Enteric Fever in the Tropics.—*Brit. Guiana Medical Annual*, 1912.

Notes on a case of Dermal Leishmaniasis in British Guiana.—*Journal of Tropical Medicine and Hygiene*, November, 1913.

Protection of milk supplies in Tropics.—*Journal of London School of Trop. Med.*, vol. II., part III.

A review of types of water supplies in British Guiana.—*Journal of Royal Sanitary Institute. Col. Supplement*, 1913.

PAPERS RECEIVED.—Nursing Times, Clinical Journal, Clinical Excerpts, Hospital, University College Hospital Magazine, Journal of Clinical Research.

Two Cases of Anæmia.

CLINICAL LECTURE BY DR. J. FAWCETT,
December 3rd, 1913.

GENTLEMEN,—The first case I wish to bring before you to-day is that of a young woman, Elsie S., æt. 16, who was admitted into Miriam ward on October 27th for weakness and palpitation. The only point of importance in her previous history is, that she was under treatment by Mr. Steward three years ago for tuberculous disease of the skin of the left lower extremity, for which treatment by means of X-rays was adopted.

The present illness had been coming on gradually for many months, and about two weeks before admission she became worse, complaining of pain over the cardiac region, of palpitation, and of inability to walk, owing to shortness of breath. The feet have swollen slightly, weakness and pallor have also somewhat rapidly increased, and at times she has suffered from headache in the frontal region.

Condition on admission.—The patient is described in the report as being extremely pale, the skin of a slightly greenish tinge; there is a little œdema of the feet and legs. Another point of importance is that, above the site of the old tuberculous ulcer, the skin, over an area the size of half-a-crown, is very painful to touch, slightly raised and reddened, and a second similar, though smaller, patch is present higher up the leg.

Heart.—The cardiac impulse was felt best in the fifth intercostal space, just outside the nipple line, and over it a soft systolic bruit was audible, traceable toward the axilla. This bruit is also traceable some distance upwards towards the pulmonary area, and in the latter situation it is replaced by a very harsh systolic murmur. There is also a similar, perhaps even harsher, murmur to be heard over the area included in and between the second and third intercostal spaces, to the right of the sternum.

The blood-count on admission was as follows:

Red cells	...	3,200,000
White cells	...	5,500
Hæmoglobin	...	... 15 per cent.
Colour index	...	... 0·23

There were no special variations found in either the shape or size of the red cells, and no nucleated cells were visible.

There were no other signs of organic disease to be discovered in any region of the body. The temperature reached 100° F. immediately after admission, but in twenty-four hours fell to normal, and has remained so since, *i.e.*, for more than five weeks.

The points to which I wish in particular to draw your attention are the association of the severe anæmia with the very well marked cardiac murmurs, and the absence of signs of involvement of any other viscus in the body.

The causes of anæmia are so numerous that I do not propose to attempt to enumerate them, but from a reference to the table on the board you will see that I have divided them up into the usual forms, namely—(1) Primary, (2) Secondary, and having put out of court such cause for the anæmia as repeated hæmorrhages from any source, and any of the so-called blood diseases, I would direct your notice to chlorosis and chronic malignant endocarditis, the two diseases between which lay our choice of diagnosis.

When the patient was first admitted, the severity of the anæmia and the very marked character of the heart murmurs, with dyspnœa on exertion and cardiac pain, were thought by us to indicate the presence of organic heart disease, and probably a *chronic* malignant endocarditis; therefore we will, in the first place, consider together this group of cases. It is a group to which Dr. Taylor alluded several years ago in our Guy's Reports, and one which has been amplified more recently by Sir William Osler—a group in which deterioration of health is often so slow that quite a long time may pass before symptoms of sufficient severity appear to lead patients with this disease to consult a doctor. In many of them unchanging signs of cardiac disease have been known to exist for a long time, and a previous history of acute rheumatism is frequently obtained. In most there is no evidence of how they become infected. The duration of life after the symptoms due to infection first appear may be six, eight, ten or twelve months, or even longer, and, as you may imagine, they often form in consequence most difficult diagnostic puzzles.

Perhaps the features which first lead us to suspect the supervention of malignant endocarditis are attacks of fever, sometimes protracted, at others of a definitely remittent type, and with it a progressive anæmia, though the anæmia may not be obvious till quite late in the course of the illness. I have often heard students say that one of the most characteristic diagnostic features of malignant endocarditis is the change which takes place in the cardiac

murmurs. This is by no means true, at any rate, in the type of chronic cases which we are considering to day; indeed, it is rare for any striking change to occur in the character of the murmurs even in the later stages when the patients are very ill, in spite of the fact that extensive changes are taking place in the valves.

A sign of great importance in this class of case is one to which attention was specially drawn by Sir William Osler, namely, the presence of small tender, raised erythematous nodules in the skin which come and go, which are most commonly situated on the tips of the fingers, the pads of the toes, the skin of the lower part of the arm, and occasionally in other parts of the body. It was suggested that the two erythematous areas present in the case of our patient were of this nature, but it seemed doubtful if this was the case, and no others appeared at the more common situations just mentioned. A typical case of this group is given in the following abstract of one of Sir W. Osler's cases:--A girl, æt. 20, had suffered from rheumatic fever five years previously, with subsequent cardiac complications. In February of the year in question she had tonsillitis, and had not been well since. She had become pale, weak and nervous, and some weeks later commenced to have pyrexia, febrile attacks occurring off and on throughout the summer. General wasting, with anæmia, gradually supervened. In October of the same year the pyrexia became more marked, reaching 100° to 102° F., and at times the patient suffered from drenching sweats. Later, considerable irritability of the stomach occurred, and on several occasions very tender erythematous spots appeared on the tips of the fingers. The heart, which was somewhat enlarged, and over which a loud mitral murmur was heard, did not exhibit any obvious change during the course of the illness. Death occurred about twelve months from the onset of the tonsillitis.

In arriving at a diagnosis of chronic malignant endocarditis, most help is to be obtained from (1) a knowledge of the existence of a previous cardiac lesion, for it is in this group of cases that chronic malignant endocarditis most often occurs; (2) the appearance of embolisms such as lead to enlargement of the spleen, to cerebral embolism, to hæmaturia, and other symptoms; (3) the association of special affections of the skin, such as purpura, or of the erythematous nodules to which I have already referred; (4) pyrexia, and (5) progressive changes in the heart.

In the case we are considering to-day it was impossible to come to a diagnosis at first, and it forms an illustration of the great difficulty which may arise in differentiating between organic disease of the heart and cardiac murmurs due to anæmia. At the present time, some five weeks after admission, the position is different. The cardiac murmurs have much diminished in intensity, and that at the apex has disappeared; the temperature has been quite normal since the day after admission; the condition of the blood has markedly improved, as also that of the general state of health of our patient; there have been no signs of embolism in the eye, the brain, the peripheral arteries of the limbs, or other structures, and the examination of the blood for organisms was negative.

Thus we are led back to the other disease which I mentioned, chlorosis. Clorosis is, as you know, a disease of females, affecting young women most commonly between 15 and 25 years of age, associated with breathlessness, lassitude, anæmia, with a peculiar greenish tinge of complexion and with special blood changes, all of which features existed in our patient.

I have already referred to the fact that in some cases the presence or absence of pre-existing valvular disease may be very difficult to ascertain from the character of the murmurs, and the only way in which a diagnosis can be arrived at is by observing the response to treatment. In this case the apical systolic murmur has almost, if not quite, disappeared, and those at the base are softer in character, though they still maintain a harshness rather exceptional in one who has reacted to treatment so well as this patient has done.

We will next refer to the blood changes. There can be no question that, in this patient, the degree of anæmia was extreme, but even 15 per cent. of hæmoglobin is not unknown, although, on the average, when a patient with chlorosis first comes under observation, the percentage varies between 25 and 35 per cent., and is seldom lower.

As regards the number of red cells, the 3,200,000 enumerated is about the average, and even though the percentage of hæmoglobin was so low in this case, the characters of the blood picture are those of a chlorotic blood in which the diminution in the number of red cells is small as contrasted with the percentage amount of hæmoglobin.

The other important point to which I wish to direct your attention, and which conclusively

proved to us that the case was one of chlorosis, was the effect of treatment. The patient has, of course, been in bed throughout, and she was at first given a mixture containing Liquor arsenicalis ♏ v. and Ferri et Ammon. citratis grs. vi. t.d.s. Twelve days later a further blood-count showed:

Red cells 2,900,000
Hæmoglobin .. ... 20 per cent.

At end of 3½ weeks:

Red cells 3,900,000
Hæmoglobin ... ... 40 per cent.

The arsenical mixture was then omitted, and the patient was put on two Blaud's pills three times a day, and this dose was rapidly increased until in six days' time she was taking five Blaud's pills three times a day. Eleven days after commencing this treatment another enumeration was made, and this shows the striking improvement effected in a short space of time by the substitution of rapidly increasing doses of iron for the previous treatment.

At end of 5th week:

Red cells 4,900,000
Hæmoglobin ... ... 70 per cent.

Three days later she was put on six Blaud's pills three times a day, and on her discharge the blood-count was as follows;

Red cells 5,200,000
Hæmoglobin ... 75 per cent.

Thus, the point of special importance in the treatment is, that rest by itself is not sufficient to cure a case of chlorosis, especially so severe a case as this one; that the bland preparations of iron, even when combined with arsenic, are likewise insufficient; that it is necessary to give iron in an inorganic form, if possible, and in large and increasing doses. There is no doubt that the more elegant preparations of organic iron which have been placed upon the market are not nearly so useful as the inorganic salts, and many of them contain too small a proportion of iron to be of much value. In fact, the only conditions in which organic iron preparations should be used are those where the irritability of the stomach is so great as to be unable to tolerate the inorganic preparations.

The second case, for which I see time will limit our consideration, is that of a man, æt. 44, who was engaged in a wine and spirit warehouse. He was admitted on November 14th, having been found in the mud at the side of the river, without any knowledge of how he arrived there.

On admission, the most striking feature about him was his anæmic appearance. The history he gave of himself was as follows: that for about six months or more he had been short of breath on exertion, and latterly quite unable to climb a flight of stairs without considerable distress and pain in the precordial region. For some two years he had been losing at intervals a considerable quantity of blood from internal piles. He had taken alcohol freely over a long period, though not in excessive amounts at a time.

Condition on admission.—The patient is a big, very pale man, well covered with adipose tissue everywhere; his skin is of a pale lemon-yellow tint, and even when lying in bed he is somewhat dyspnœic.

The position of the cardiac impulse could not be determined; there was a systolic bruit audible in the fifth left space, vertically beneath the nipple, traceable outwards for a short distance, and upwards towards the base. There was also a soft systolic bruit over the base of the heart, perhaps somewhat louder at the right than at the left edge of the sternum. The cardiac dulness did not extend over an area greater than the normal.

There were some large piles projecting at the anus. No physical signs of disease in other organs were discovered, and the liver did not appear to be enlarged. The urine was normal, and there were no hæmorrhages in the retina. The maximum systolic pressure reached about 150 m.m. Hg.

Again, the question arose to which of the multitudinous causes of anæmia this patient's condition was due. The possibility of a primary anæmia, such as a "pernicious anæmia," at once occurred, on account of his general adiposity and peculiar tint of skin, but the examination of the blood excluded it, for the red cells gave a varying count of 3,100,000, 2,700,000, 2,900,000, in three consecutive counts. The hæmoglobin was 27 to 30 per cent; the white cells 7,200 to the c.mm. The colour index was 0·5. Although the red cells differed somewhat in size, as one would expect in so anæmic a condition, yet there were neither nucleated cells, megaloblasts nor megalocytes to be seen. Again, too, in pernicious anæmia there is, as a rule, a leucopænia. In this case the white count was normal. Thus, the low colour index and other features put "pernicious anæmia" out of court.

On referring to our table once again, one or more of the following causes were those which appealed to us, viz., repeated hæmorrhages

from the piles, a toxæmia (the result of alcohol or syphilis), the cachexia of malignant disease, and an anæmia associated with the cardiac lesion. Other conditions due to chemical poisons such as lead, mercury, aniline dyes, and diseases due to intestinal parasites, were, so far as we could determine, not present in this case.

To take, first of all, the question of repeated hæmorrhages from the piles. It had no doubt been considerable, and Mr. Rowlands, who kindly saw the patient with us, was of opinion that a great deal of the anæmia, if not all, was due to this cause.

The type of anæmia as represented by the blood-count was that of a secondary anæmia, and it is well recognised that after *repeated* hæmorrhages the regeneration of red cells is much less rapid than after a single large hæmorrhage. At the same time, the condition of this man's blood did not improve at all during the month he was in hospital. He was kept for a considerable period at complete rest in bed and on full diet. He was given Liq. Arsenicalis in increasing does until he was taking a mixture containing ♏ viij. three times a day, and in addition some Blaud's pills. Nevertheless, four weeks after admission, although he had improved greatly as regards his general state of health and shortness of breath, and was able to walk about freely and in comfort, yet the blood-count showed red blood cells 3,120,000 and hæmoglobin 32 per cent.

Therefore, as the patient had not bled at all since he was admitted, and even allowing for regeneration of red cells taking place slowly, yet if the anæmia had been the result of loss of blood alone, some improvement in the blood picture ought to have occurred in four weeks. Consequently we bethought ourselves of some additional factor which, acting as a poison over a long period, might have impaired the functions of the organs and tissues of the body, and incidentally the power of the red marrow to regenerate blood cells. In this connection arose the question of the noxious influence of syphilis or of alcohol.

Syphilis we excluded on the ground that there was no sign of it, past or present, and the blood gave a negative Wassermann reaction. Alcohol, on the other hand, was, no doubt, a prominent factor in the case. To its influence we attributed the failure on the part of the patient to improve to the extent expected when the hæmorrhage from the piles had ceased.

You all recognize how that a chronic poisoning by alcohol produces a gradual deterioration of almost any, or all, of the organs and tissues of the body—that in some cases it exhibits its effect more directly on the cardio-vascular system by begetting degenerative changes in the myocardium and subsequent dilatation of the heart, and probably also in the arteries by the production of atheromatous changes in the coronary and other vessels. The so-called "alcoholic heart," claimed first, I think, by Tübingen and later by Munich, is an instance of the cardiac dilatation to which I refer.

Again, the general adiposity of our patient is best explained on the alcoholic-poisoning hypothesis, and when we think of the condition of the heart which so often exists in these fat people, we recall the heart overlaid and surrounded with fat, especially on the right side, penetrating into and replacing the muscle so that little of it remains. Dr. Wilks labels it in his book "Obesity of the heart."

We came to the conclusion that, although we were unable to determine with certainty the size of the heart, yet in all probability there was some enlargement of it, and that the dyspnœa on exertion and the anginal attacks were due to a myocardial degeneration, possibly of a fibro-fatty nature, associated with atheroma of the coronary arteries, or to cardiac dilatation, to which I have already referred; that the improvement in the general condition of the patient was due to the beneficial effect of the rest upon the heart by increasing its reserve power. It is obvious that the improvement was not due to any change in the blood, the condition of which was the same as on admission to hospital.

The bruits might be explained as "hæmic," or as due to dilatation of the left ventricle, and some insufficiency to explain the apical murmur, and to atheroma of the aortic valves and aorta to explain the systolic murmur heard in the aortic area. Again, we were unable to decide, but thought that the pulmonary bruit was hæmic and the other two not so, but rather the result of the second suggestion offered.

The question of the anæmia being secondary to the cardiac lesion did not arise in this case. There was no evidence of aortic incompetence, and none of the signs already drawn attention to in connection with the first case as distinctive of a chronic malignant endocarditis.

There is, however, one other—not uncommon—condition which, in an obscure case of anæmia, and particularly in a middle-aged patient, should never be lost sight of. I mean so-called "latent" carcinoma—carcinoma with no localising signs

of its presence, but merely those of a general progressive cachexia and anæmia. This variety is most often seen in association with the abdominal viscera, particularly the stomach. We considered it most carefully in our case, bearing in mind one of which I shall now give you a short abstract.

A man, æt. 31, a railway porter, was admitted under the care of Dr. Goodhart in 1880. He said that he had been in good health until five weeks before admission, since when he had been ailing and getting paler. On admission his anæmia was so extreme that special enquiry was made as to loss of blood. His appetite was good, he had no pain after food, and there was neither vomiting nor nausea. There was a loud systolic murmur over the heart, especially at the base, and also a slight diastolic at one time over the third right intercostal space. The case was thought to be one of aortic disease, and infective endocarditis was also discussed. At the autopsy a carcinomatous ulcer was found at the cardiac end of the stomach, with secondary growths and abscesses in the liver.

I do not think you could have an example better illustrating the difficulty of diagnosis of these so-called cases of "latent" cancer, and I hope it may serve to impress this group on your minds when you come to deal with an anæmia obscure in origin, such as the one I have brought to your notice to-day.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—Will you allow me, through your columns, to thank most sincerely the members of the Revision Class for the last Final L.D.S. examination for the extremely handsome inkstand which I received from them this week.

The confidence and friendship of the men is a source of great pleasure to me, and their gift will be to me a much-prized memento of our pleasant association together.—Believe me, Sir, yours sincerely,

F. N. DOUBLEDAY.

4, St. Thomas's Street,
London Bridge,
January 24th, 1914.

Pass List.

Royal College of Physicians of London AND Royal College of Surgeons of England.

FINAL CONJOINT EXAMINATION, JANUARY, 1914.

Medicine and Surgery.

*Bailey, E. R.	Sharpe. H.
*Boswell, P. R.	*Trounce, T. R.
*Pritchard, G. B.	

Medicine and Midwifery.

Anthony, C. M.	Hanafy, M. Z.
Dean, C.	

Medicine only.

Beattie, F. A.	Galloway, W. D.
*Broome, F. C. S.	Pratt, G. A.
Drew, A. J. K.	

Surgery only.

*Jones, D. W.	*Thavara, M. C.
McManus, D. M.	*Tooth, F.
*Pryn, W. R.	Whitworth, H. P.
*Sherris, C.	

Midwifery only.

Elliot, H. H.	Minns, A. N.
Harper, C. H. L.	*Pedley, C. F.
Jones, D. R.	Wilson, S.

* Denotes completion of examination.

SECOND CONJOINT EXAMINATION, JANUARY, 1914.

Anatomy and Physiology.

Bulleid, A.	Laver, C. H.
Gokharker, G. R.	Noott, G.

FIRST CONJOINT EXAMINATION, JANUARY, 1914.

Part I.—Chemistry.	Part II.—Physics.
Apergis, H. D.	†Tonkin, B. M.
Hubbard, G. R.	†Vincent-Brown, C.
*Magill, A.	

* Passed in Part I. only. † Passed in Part II. only.

Part III.—Elementary Biology.

Bradnack, G. A. A.	Robertson, J. C.
Long, H. D.	Woodroffe, B. C.

Part IV.—Practical Pharmacy.

Abd-el-Al, A.	Rathier-du-Vergé, P. F. J. L.
Anthony, A. L.	
Hanafy, M. Z.	Scott, F. G. L.
Jones, D. R.	Simons, G. E. L.
Pryn, R. H. C.	

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

PRELIMINARY SCIENCE EXAMINATION, JANUARY, 1914.

Part I.—Chemistry.	Part II.—Physics.
Allen, N.	†Grobbelaar, P. E.
*Bloom, G. F. H.	Kopelowitz, E.
†Danks, G. H.	Martin, C. R.
†Deeks, G.	*Pretorius, W. J.
†Eglington, D. C.	Salsbury, F. R.
Evans, J. A.	†van der Spuy, D. C.
Faustmann, G. F.	*Vogt, H. V.
Fox, H.	

* Chemistry only. † Physics only.

Eugenics and Some Modern Social Problems.

A Paper read before the Guy's Physiological Society by G. H. FITZGERALD.

I'm not denying the women are foolish: God Almighty made 'em so to match the men.

GEORGE ELIOT, *Adam Bede.*

MR. CHAIRMAN AND GENTLEMEN,—I cannot help feeling that in reading you a paper on Eugenics I am taking up your time under false pretences. Of what is popularly known as eugenics, that is to say, genetics, pure and simple, I know next to nothing.

I am quite unable to tell you whether polydactylism or hemophilia are recessives or dominants, and I should be powerless to advise John Smith as to the advisability of his marrying Mary Jones, she being an albino. I am, moreover, perfectly content to leave the specialists to argue over such problems as diathetic reversion and cumulative inheritance, atavism and spontaneous variations, and other shibboleths of the scientific mind, preferring to inquire in an entirely unscientific way how this science or cult of eugenics is likely to affect, and is in its turn affected by, existing social conditions.

A short time ago Major Darwin described it as a baby science, and while this is by no means a comprehensive definition, it is near enough. Eugenics *is* the science of babies, but in a way more far-reaching than the Eugenical Society have yet dreamed of. It is a matter which involves all and every social reform from pheasant-pecked mangold wurzels to the minimum wages bill, and which has, in its turn, been directly affected by every piece of legislation from the days of King John and Magna Charta until now.

And at the very commencement we need to consider marriage. Marriage, obviously enough, may be looked at from many points of view. On the stage and in novels it is regarded merely as the climax of human courtship, in law as the union of two lines of property descent, by society as conferring a certain social status on the parties, whilst to the eugenist, who regards its biological aspect, it is an experiment in breeding.

As the average conditions of marriage are good, so will the chances of the offspring be good; if, on the other hand, the conditions are bad, if, for example, the age for marriage is deferred to a period when the procreative activities have passed their zenith, then the marriage conditions from a eugenic standpoint are bad. If the future mother has been forced to work under unhealthy conditions before or during pregnancy, if she is ill-housed or ill-nourished, if the offspring is reared under home conditions that are enfeebling, if it lacks suitable food, suitable clothing, proper care or medical treatment, then again, eugenically the marriage has been a failure.

The present is, as a bishop might very fitly remark, an age of doubt. Certain it is that a lot of our preconceived ideas are in the melting pot, and not least among them has been the current notion of woman's place in nature. For long we have been accustomed to say with unction that the hand that rocks the cradle rules the world, or to repeat in a lyric outburst the dictum of a distinguished physiologist, "The peasant woman gazing with longing eyes upon her child at her breast has an experience of the purpose of life which the highest intellectual gifts alone cannot supply." Being a practical nation, however, we take good care not to live up to our ideals.

Let us briefly consider our attitude with regard to sex. It is a subject with which we are satiated at the moment. The popular press, having discovered that what is ironically referred to as the public mind likes its indecency served up on a moral or philosophical platter, bombard us with "White Slave" meat, and their alluring posters present for our solution such questions as "Should men marry?" "Should wives be faithful?" "Should English wives wed alien hubbies?" "The Church, Gaby, and the sex problem"; and all the world from archbishops to respectable bacteriologists has rushed into the fray.

Indeed, I am sometimes tempted to believe that of all hypocrites your thorough-going man of science is the worst. You may point out to him some abuse that cries aloud to heaven for redress and he will fold his arms complacently and repeat to you a scientific catchword. You quote to him statistics of infantile mortality: "An excellent thing," says he, "this is a proof of the working of the great law of the survival of the fittest"; precisely as his brother in the church lifts up his voice after any great calamity, saying, "Ah, my brethren, how inscrutable are the ways of Providence." "In New Zealand," says someone, "the birthrate has gone down 30 per cent." "Woman's Suffrage," says the scientist, shaking his head; forgetting that in Europe every country that has not the suffrage, save savage Roumania, has witnessed a similar decline.

Limitation of the family is grossly immoral, says your physiologist, ignoring the obvious truism that the parent has a moral obligation to his offspring, and that from a eugenic standpoint it is sounder to have three children well cared for, well clothed and well educated than a dozen reared under unfavourable conditions.

Once again he falls into that pitfall of the superficial thinker: "The survival of the fittest." "Breed plenty of children," he says, "expose them to hard conditions, immolate them if you will, the survivors are more likely to be men of genius than those that perish." Though, of course, it is common knowledge that many of our greatest geniuses have been men of sickly health, and if not the only child, at least one of a family of two or three. Moreover, the finest

genius is notoriously sterile, but according to physiological ideals the tramp woman confined every year in the Infirmary is doing the world a greater service than the author of "Mrs. Warren's Profession," or the perfector of the internal combustion engine. The scientist, too busy with social theories to inquire into economic facts, seeks to solve all our modern problems in the light of his observations on a sub-species of the lepidoptera.

Yet, in spite of the sentimentalist, the physiologist, and the pornographic reporter, *there is* a definite tendency to alter our sex standards and ideals, a movement, variously named and not always very rationally conducted, which is sometimes known as "Woman's Suffrage," sometimes the economic emancipation of women, and which includes amongst its desiderata "The State Endowment of Motherhood."

Primitive man, owing probably to the merely physical attributes of strength of aim and swiftness of foot, seems to have established himself as head of the family. (Social historians, it is true, speak of a period known as the primitive matriachate in which the woman was recognised as the head of the gens, whilst the man was of use mainly to fertilise the female, and I am told in Central Africa there exists a tribe still showing this condition, but I have been unable to obtain any data.) To the woman he relegated most of the really useful functions, tilling the soil, preserving the produce, making of garments, tending the young, etc., as in primitive tribes to-day. The men killed beasts, and brought them home, and spent their leisure in mending weapons and holding momentous pow-wows, for all the world as if they were civilised party politicians.

As civilisation progressed, men continued to maintain the headship still through their strength and ability to defend the home, so that when much later a little learning became the fashion, here, too, women were kept in subjection, not because they were men's mental inferiors, but because a man had no wish to be floored by the logic of the wife of his bosom. A demand for fools being thus definitely established, there was no lack of women to supply the demand. The few who revolted either entered nunneries or were burnt as witches, these being the only two possible outlets. There was, however, a constantly increasing surplus of women, and though no doubt it was possible to utilise them in some fashion, what they did must ever be one of the mysteries of social history. Towards the end of the 18th century, however, woman, married and unmarried, began to be employed in increasingly large numbers in factories, and though the more genteel classes kept their daughters at home till the eighties, the problem of the surplus woman was beginning to be solved.

The advent of the "New Woman" of late Victorian fame marks the coming of the new epoch. The suffrage movement is primarily due, not so much to the growth of a new spirit, as to new economic conditions. As long as marriage offered to women an assured position, however degrading, the fool which man had created in his own image was bound to accept it. When the stress of increased competition caused the age for marriage to grow gradually later, women, willy nilly, cast about for other occupations. The swoons and vapours, physiologically correct as Dr. Pembrey assures us, of our grandmothers vanished, and the young lady, now a mere young woman, for the first time entered the field of competition with men. That she has justified her entry I need not dispute. There is not a profession or business in the world where women, when allowed an equal chance with men, have not proved themselves their equals.

It is useless for the moralist to point a stern finger towards "hearth and home," or the physiologist to murmur "unsexed"; they are content to leave in the drawing-room that essentially masculine product, "the womanly woman," whilst they go about the world, conscious of their powers and their worth, toiling, suffering, occasionally dying in some high endeavour, a living refutation of the poet who said—

Women, you'll observe, don't suffer for a cause,
They suffer for a man.

The bearing of this on eugenics is not far to seek, for it may be held to symbolise a revolt, not against motherhood, though that, too, is present, but against marriage. The two are not synonymous, as is loosely supposed, however existing conventions tend to make them so. The position of the spinster in Shaw's "Getting Married" is by no means unique. There are many women who will not marry because they cannot bear the smell of tobacco smoke in the curtains. There are many women who consider a lifetime's service to a man, since this is the only condition under which they may bear children, a lifetime of subservience, of submerged individuality, too high a price to pay for the privilege of motherhood. It is not enough that they are mothers, they must be mistresses as well. And this is the point of view that I would so strongly impress on you. The refusal of many women of the educated and independent classes to marry is not a sign that they are "unsexed"—since "unsexed" can only mean that they are not the slaves of their appetites. The truly unsexed woman is your wife of the upper or middle classes, who bears a child or two under protest, relegates them as soon as possible to the care of a nurse-girl, and spends the rest of her life in idleness, in Bridge Teas and Tango Teas, in shopping and charity bazaars, in that endless search for the anodyne of gaiety which is the penalty of all those who pamper the instincts and starve the soul; who is, in a word, the ignorant mother of our physiologist turned loose on the world with wider possibilities for evil.

In the working-classes the problem is more acute, for the better-class woman, whatever her moral posi-

tion may be, is at least well fed and well housed. Let me quote the words of a well-known woman writer (Mrs. H. M. Swanvick): "The fact remains that, especially among working people where the woman can have no money of her own unless she is in a position to earn it, the husband has the most awful powers of inflicting torture and wretchedness upon his whole family, and that it is distinctly safer for a working-woman not to be married to the man she lives with," and contrast it with the ideal mother of the physiologist: "Her womanly charm was more effectual," he says, "than reason in influencing man in her favour; her natural tact and intuition were more useful than a logical argument." Picture, if you can, the effect of womanly charm on a wife-beating husband, come home drunk on a Saturday after spending the greater portion of the week's wages.

I have some interesting figures which, if I may, I would like to quote. A census was taken of all the surviving students of Mount Holyoak College for Women in U.S.A. between 1840 and 1910; some 6,000 students graduated, so that no fewer than 2,827 replies were received. The figures are, we may suppose therefore, thoroughly representative. They are as follows:—

	Spinsters, per cent.	Wives or Widows.
1842—49	15	85
1850—59	25	75
1860—69	39	61
and so on gradually increasing till in the last period		
1900—09	76	24

The figures are, I think, sufficiently striking. Moreover, this type, the enterprising college girl is precisely the sort whom we want as mothers. Even amongst the next most desirable type, the good, physically sound, if unenterprising woman of the better classes, things are bad. Indeed, if one were pessimistic one might be tempted to assert that eugenics has not come too soon into the world, but too late. For we have suffered motherhood to become unpopular. In these classes children are no longer regarded as the natural outcome of a marriage, but as misfortunes which befall the unwary.

In the middle of the last century Malthus, when he preached his doctrine of the limitation of population to existing needs, meeting the fate of all those who have the courage to proclaim what all the world has tacitly agreed upon, was execrated, and his book proclaimed as subversive to public morals. As is usual, in these cases, however, people immediately began to follow his precepts, in the letter rather than the spirit, and the means for the sterilisation of marriage being to hand, proceeded to cut down the birthrate as fast as decency and a conservative tradition allowed. How far the movement in this direction is likely to go, it is hard to say. Nowadays the family of ten or more more is limited to about 1 in 1,300 families, whilst we know ourselves that a family of five or six is thought large.

Let us now turn for a moment to the woman who is neither educated nor in easy circumstances, to that class who form, in fact, the great majority of the nation's mothers. Far be it from me to harrow you with a relation or even a glimpse of some of the pictures one can piece together from an examination of Blue books on the employment of women, casual references in police-court reports and coroners' inquests, or from such books as Mrs. Pember Reeves' "Round about a Pound a week," or Seebohm Rowntree's monumental work, "Industrial Poverty." The poor are naturally reticent; for the sake of our own complacency let us be thankful that they are so. Let me quote you a few figures from the recent conference on "Sweated Female Labour," presided over by the Duchess of Marlborough. Some two million women and girls are employed in factories and workshops in Great Britain, and about 100,000 more in home occupations, such as sempstress work and matchbox making. Of these at least 300,000, probably more, for a full week's work, twelve hours a day for six days, receive a wage of under 12s. (The total average wage of 14s. for the two million working women is only arrived at by including the Lancashire women, who are employed on an equal footing with men.) In many employments the wages range from 8s. or 9s. to 6s. for a full week's work; indeed, one East-end firm of capmakers pays its girls 2s. 6d. per week. Thousands of them are suffering actual hunger, want, and starvation, although they work every available moment the whole year through.

The home workers' state is even more pitiable; a large percentage are mothers, but their home duties have to be neglected to earn the necessary pittance for food and shelter. The children are underfed, ill-clothed, suffering from neglect, and frequently from maladies which the wretched mother has no time to tend. Complaints to the employers are of no avail; employment is either withdrawn, or a coarse hint is given as to an easier means of earning one's money. Indeed, in most occupations open to the working woman, the wages are notoriously cheapened by prostitution. Of the woman who has born a child without first providing herself with a male protector, I need say little. If her sense of motherhood be strong, she may, if she be fortunate, obtain admittance to a "Rescue Home," where, submitting herself to the ministrations of callous matrons and half-baked curates, she may atone for the sin of maternity. Most, however, seek the traffic of the streets, there to expiate the crime of bringing a child into the world. For those less enduring the Thames is generally relied on to provide a last resting place.

These are a few of the aspects, very hastily and imperfectly shown, which the eugenist has to consider with regard to the status of marriage. Firstly, as we

have seen, the growing disinclination of cultured and educated women to marry; secondly, the growing tendency to restrict childbirth amongst their married sisters; and thirdly, the appalling conditions amongst which the women who *do* bear the bulk of the nation's children are forced to live.

A walk through the Borough, however, will convince anyone that children, not of the best sort, perhaps, but undeniably children, are not lacking. But what proportion of these heedlessly begotten children ever reach maturity or even, say, five years of age. In Rutlandshire, where the infant mortality is the lowest in England, 103 of every 1,000 infants die before attaining that age; in Lancashire, where it is highest, it reaches the enormous total of 274 per 1,000.

Now this means, unless we assume the children of Lancashire to be inherently weaker than those born in Rutland, an assumption we have no reason to make, that at least 171 out of every 1,000 were killed simply and solely by the conditions into which they were born, a total of 21,000 needless deaths per annum. Nor does it follow that the figure 103 for Rutland represents an irreducible minimum. In country districts many infants are killed by injury at birth or by unclassed "violence"; in this respect their figures are three times as high as in the towns where the mortality is highest, Preston, Leicester, and Blackburn. True, many of those who die are children who, under eugenic conditions would never have been born at all, the offspring of the tuberculous and syphilitic, for example. Nevertheless, we have then remaining an enormous margin which represents the toll the nation pays as a direct result of neglect and incompetence. A waste such as this, no doubt inevitable amongst young and struggling nations, is a sign of impending disaster in an older civilisation. Since 1876 our birthrate has been falling, slowly at first, now faster; but as a nation we cannot deplore it. A people which deliberately wastes child life has no right to clamour for more to send along the same road.

In 1846—50 the rate was 33·8 per 1,000 of population; in 1876 it reached a maximum 36·3; in 1912, the latest date for which official figures are available, it sank to 24 per 1,000. Now a fall like this may be due to many things. It might, for example, be caused by the prevalence of gonorrhœa, which is a great cause of sterility, or, on the other hand, by solicitous husbands refusing to allow their wives to bear a child more than once in three years. Thus, we have two possible causes, the one beneficial, the other noxious, which would have to be taken into account. Moreover, figures like these are entirely deceptive, since the true method is to set them against the rate of increase or decrease of the deathrate.

This in 1846—50 was 23·3, in 1912 13·8, a decrease of 9·5 per 1,000; subtracting this from the difference in birthrate in these two periods, viz., 9·8, we get the effective rate of decrease of the population as ·3 per 1,000. To return, too, for a moment to the question of infant mortality, the average rate for 1911, a bad summer, by the way, was 130 per 1,000. Amongst the professional classes, however, it sinks to surprisingly low figures: for army officers, 44; naval officers and solicitors, 41; doctors, 39; and artists, 27. Such figures show how little of our infant mortality is really inevitable. Given the intelligent care that is bestowed upon the child of the officer, solicitor, or practitioner, there is no reason why 45 should not represent the average infant mortality for the kingdom. Granted this, our decrease of ·3 would rise at once to an increase of ·6 per 1,000, by lowering the deathrate to 12·9; this in 1911 when the deathrate was ·6 above the average of the last three years. The fall is to some slight extent due to a fall in the percentage of illegitimate births, which in 1848 was 2·2 per 1,000 and is ·98 (for 1911). It is due, again, to the increased number of people alive, who have passed the age for procreation, and it is due most of all to the growing disinclination for marriage and maternity.

These few figures, and I heartily apologise for having had to trouble you with them, *do* give us some tangible idea of the problems we have to deal with. And now, since I am aware that so far I have been mainly destructive, let me offer a few suggestions, purely Utopian I assure you, which might remedy this state of affairs. The first, and I proffer it in exceeding humility, is the granting of the suffrage to women.

So long as the major portion of the community is subservient to the other (in 1911 the females in the United Kingdom outnumbered the males by 1,333,380), unrepresented in the Government, without legal means to voice their opinions or obtain redress for their grievances, so that she may be sweated, oppressed, driven to prostitution without fear of influencing the polls; so long as you have the greater number of these women forced to join themselves, licitly or illicitly, to some breadwinner to gain the necessaries of life; so long as you can recognise no other relation between man and woman save the sex relation, and allow her no economic value save her sex value, so that wit and virtue are less valuable than secondary sexual characteristics, and a senior wrangler has less chance of success than a Gaiety girl; so long will you continue to degrade motherhood, forcing into marriage the effete, the unambitious, the unresisting, leaving the highly educated, the more aspiring, to forego motherhood rather than submit to its restrictions.

Moreover, in such countries as have granted the suffrage to women, *e.g.*, the United States, where in more than one-third of the States the suffrage is an accomplished fact, one notes an immediate change in the character of the legislation. From the normal apportionment of men's and women's work and interests it is evident that, in the main, men will be more concerned for property and women more concerned for the person, and the subjects for legislation

in these suffrage states amply bear this out. Contrast such legislation as the following with our own Ulsterian paroxysms: an eight or nine hours' day for women, provision of women doctors for asylums, pure food bills and the inspection of slaughter-houses, the establishment of juvenile courts, industrial schools and schools for parents, attacks on child-labour and the insurance of young children, equal pay for men and women teachers, and the recognition of the joint responsibility of fathers and mothers—this is the kind of bill a woman's suffrage State concerns itself with. Think, too, that under man-made legislation there is no maternity benefit under the Insurance Act for the female contributor who cannot show her marriage lines! In Alaska, women were enfranchised in March, 1913, and the reason they gave was significant: they have too few women in Alaska, they said, and they want to attract them to come.

The second of these suggestions is the State Endowment of Motherhood. It is obvious, or, rather, should be obvious, that a woman who has been able to rear a healthy baby is a person who has performed a service of definite value to the State, and to such a woman the nation is a debtor. Whether she be married or unmarried, virtuous or a prostitute is immaterial, for private morality is no concern of ours. The sole criterion is her fitness to rear her offspring. Such a scheme is already in operation in Denmark and in some 14 States of the American Union. Starting with the assumption that the home is better than the Institution, and that the child should not be deprived of home influence, when poverty was the only bar to prevent the mother undertaking its upbringing, an experiment was made to allow the mother, when deprived, either by death or desertion, of the support of a breadwinner, a fixed sum per annum, in most cases £15 supplemented by additional grants, for every child reared under home conditions that satisfied the Commissioners, one of the conditions attaching to the pension being that under no circumstances may work be undertaken outside the home. The granting of pensions and supplementary sums from the fund for outdoor relief is made by the judges of the Juvenile Courts.

The schemes vary a good deal in practice, but the idea upon which all are based is the idea of the Minority Report of our own recent Poor Law Commission, that the mother of young children is doing a better service to the community and one more worthy of remuneration when she stays at home and tends her children than when she goes out to low-paid labour and leaves them to the care of a neighbour or hireling or to the chances of the street. Further, that she is in no sense degraded by receiving public money. On the contrary, she is paid for rendering a civic duty, and her position is determined not by her poverty, but by the fact of the duty's fulfilment. She is kept from self-support only by the future citizens at her knees.

One could imagine an extension of this idea, as Mr. H. G. Wells suggests, whereby a minimum standard of clothing, growth, cleanliness, nutrition, and education would be set up, and if that standard was not maintained by a child, or if the child was found bruised or maimed without the parents being able to account for these injuries, the child should be at once removed from parental control, and the parents charged with the cost of suitable maintenance. If the parents failed in this respect they could be put into celibate labour establishments to work off as much of their debt as they could, and they would not be released until that debt was fully discharged.

And thirdly, and lastly, let us consider the education of girls. Dr. Clement Dukes, in the article on "The Hygiene of Youth" in Albutt's Medicine, an article which I commend to every eugenist, says, "The education of girls nowadays is effeminate, whereas it should be feminine." How true this is one can gauge by imagining what reception a course of lectures on the "Value of Breast-feeding" would receive at a select establishment for Young Ladies. It has, of course, always been customary to regard the essential facts of life as too indecent for mention by any save the lower classes. But whilst in the times of our grandmothers these "secrets of the alcove" were imparted either by some old family servant, or by the mother herself, most modern parents seem content to leave their girls' sexual instruction to the furtive confidences of schoolmates or the silly prurience of the latest shilling shocker.

Domestic science is the realm of the bungler. Our national cooking is a byeword, our national ignorance of the household arts would make the diploma'd girl of Germany or Scandinavia hold up her hands in horror. Woman—at least the kind of woman one sees at Tango Teas—no longer bakes or weaves or spins or makes medicines or even sews as she did a century ago. She has gradually been led to hand her baking over to the baker, her medicines to the chemist, her weaving and spinning to the mills. Soon she will be led to hand over her children to the Municipal Crêche, and her household to the Domestic Management Agency. Indeed, this is the only point upon which I feel sure of your sympathies, for whether man agree to flee woman as the embodiment of earthly passions, or seek her as his partner in the affairs of life; whether he regard her as his intellectual companion or as a breeding machine with the mentality of a broody hen; this, at least, he will admit, that the woman who selects marriage and motherhood as a profession in life is worthy of honour only to the extent that she is able and qualified to carry out those duties.

In Lighter Vein.

An Out-Patient's Alphabet.

A stands for "Abscess," sent round to the "Back,"
Of dressers to treat it there's never a lack.
B.'s for Bad legs, there are many of these,
They sit in a row comparing their knees.
C stands for Chivers who sits in the Hall,
And scratches his head, or does nothing at all.
D stands for "Dressers," a vast subject this,
Their socks and their ties fill our dark days with bliss.
E is for Ether at Minor Op.'s used,
The patients go home feeling, well, not amused.
F stands for Fawcett, so there's nothing to say,
Because its already been said in the play.
G.'s for Miss Grundy, her presence is felt
By patients requiring a splint or a belt.
H stands for Harky, who's now on the district,
At impromptu obstetrics he'll soon take the biscuit.
I stands for Iodine, always on tap,
For the unwary germ 'tis a terrible trap.
J is for Jones, we have them in dozens,
Some aren't related while others are cousins.
K stands for Kinks, their number is legion,
They're principally found in the iliac region.
L stands for Liniment, its the O.-P.O.'s biz
To prescribe this for patients who've got rheumatiz.
M stands for Medicine, an ounce T.D.S.,
If the patients would take it they'd trouble us less
N.'s for Novocaine, sometimes injected
That patients from much pain may be protected.
O stands for Oxygen, always so handy
When a patient's too bad to administer brandy.
P stands for Pus, not pleasant to mention,
If a patient has this he requires prompt attention.
Q.'s for Quinine that you give for a cold,
I'd not take the stuff for its own weight in gold.
R.'s for Red Tape, you'll admit that there's plenty
In Guy's O.-P.D. to run hospitals twenty.
S stands for Sister, I know for a cert
If we leave out her she'll feel frightfully hurt.
T.'s for Trethowan, of bones he's a master,
It's a pity he wastes such a lot of good plaster.
U stands for Undine for washing out eyes,
It takes pluck to submit, but you'll find that its wise.
V.'s for Vaccine, a collection of bugs
Put under the skin to save taking drugs.
W.'s for work, I wonder I've time
To put mine aside to scribble this rhyme.
X stands for X-rays, not open till three,
And then you will find that they're drinking their tea.
Y is for you, reading my Alphabet,
I shall be pleased when it's in the GAZETTE.
Z stands for Zero the state of my brain,
I'm certain I'll never write verses again.

M.C.M.

Rugby Football.

GUY'S v. NEWTON ABBOT.

It was bitterly cold at Honor Oak Park for this match on Wednesday, January 14th, which, together with the fact that it was midweek, kept many people from witnessing a very interesting match, played at a great pace, and ending successfully for Guy's by the margin of 1 dropped goal, 1 penalty goal, and 3 tries, to 1 goal and 1 try.

Medlock opened the scoring with a very nicely judged penalty kick, and Guinness soon put the Hospital more points to the good with a fine dropped goal. The Guy's forwards were playing well and repeatedly getting the ball, with the result that our backs were on the move frequently, and it was good to see them shaping like a workmanlike quartette. It seems that Steyn is not played up to sufficiently. Guinness did some good cutting through, but he will add much to his efficiency if he plies the international with some decent passes. After the above reverses Newton played up better, but the Hospital tackled well and Millett was in sterling form at full back. Once an interception by Mills looked ominous, but he was brought down. Then after Guy's had forced a minor, Newton dropped out very smartly and rushed the ball at once to the other end, where a scrum was ordered, which ended with Howard getting over for an unconverted try.

Danby went off at half-time, but although one short for the rest of the play, Guy's more than held their own, gaining three more tries, the first by Tweed after a good dribble, the second by Broster following on some good combination with Steyn, and the last was gained by Steyn who ran cleverly. All Medlock's attempts at goal were good, but the angle in each instance was very difficult. Hodge got the try for Newton which Emmett goaled. A dodgy run on the part of Steyn put Medlock in possession, but he hesitated when the line looked almost at his mercy. Towards the end the Visitors put in long kicks and quick rushes, hoping to catch Millett napping, but nothing more was done in the way of scoring, and a good game ended as stated above. Team :—

GUY'S.—H. Millett (back); S. S. L. Steyn, A. F. Guinness, N. Kendall, A. F. Rook (three-quarters); L. R. Broster, C. H. Medlock (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. S. Liebson, A. B. Danby, C. H. Laver, G. F. Kidman, A. H. Harkness (forwards).

REMARKS.—Millett's defence was superb, but it would be well to get touch a wee bit sooner if possible. Steyn and Rook both played very soundly, and I liked the centres, but Kendall must get his hands into safer condition; he dropped many passes, but he

gave some very nice ones to Rook. Guinness must nurse Steyn and make every use of him. If the ball will not go to the right could Steyn play on the left? Broster and Medlock did well, but the last named must run straight and get off the mark at once. The forwards showed much improvement. In the loose rushes they must be more together, more concerted, and go with more devil. The tackling was better. The whole side will do well to train thoroughly. Fitness is the keynote to success. A leaf may well be taken out of Newton's exhibition. Let the whole XV. be more alert, on its toes the whole time, wide awake to every situation and prompt to take immediate advantage of any and every favourable opening.

Association Football.

GUY'S v. ILFORD AVENUE.

The weather was not ideal, and as this was Guy's first match since the Christmas vacation, they were not altogether in a very fit state when they went down to Ilford to play Ilford Avenue on Saturday, January 10th. The game was very late in starting, Ilford Avenue turning up short and playing only ten men all through the game. Although their opponents' forwards had plenty of pace, it was soon evident that Guy's had an easy task before them. The ball was soon carried into the Avenue's half, and Williamson was the first to score, having run through with the ball himself. Guy's forwards continued to keep the ball, and were again rewarded by Lloyd scoring with a fairly safe shot. A penalty was given later against Ilford, which Coxon succeeded in putting over the crossbar, but he managed to score off a centre from Evans a little later on. Stebbings was the last to score in the first half with a cross shot into the corner of the net.

In the second half, with a lead of four goals, Guy's did not keep up the same pace as they did at the beginning of the game. Williamson, however, succeeded in running right through and scoring again, and Stebbings also added another before the end. Meanwhile, Ilford pulled themselves together, and taking advantage of a momentary collapse of Guy's defence, scored their only goal, making the result 6 goals to 1 in Guy's favour.

REMARKS.—The team as a whole does not seem to have suffered much from the effects of the Christmas holidays. The forwards are working more together, but there is still a great deal of individual play that must be dropped before they will be fit for a cup-tie. The outside men wait too long, or endeavour to come in too far, before they centre. Bevis, at centre-half, works very hard, but should pass back more often when hard pressed by the opposing forwards. Kyle was very unsteady with his kicks, but it is to be hoped that it was merely an off day.

GUY'S v. BANK OF ENGLAND.

On Saturday, January 17th, Guy's pulled off another victory by beating the Bank of England in a very good game by 2 goals to nil. It was a very fast game, the pace being kept up all through. Guy's got the ball first and proceeded to attack their opponents' goal, but the play was soon transferred to the other end of the field where, however, Guy's defence was equal to the occasion. The ball continued to pass thus rapidly up and down the field when Williamson centred and both of the Bank's backs successively miss-kicking the ball, Coxon was left with an easy shot. The Bank were unable to reply and the score was 1—0 in Guy's favour when we changed over. In the second half Guy's gained considerably more of the game, although the Bank made some very formidable attacks, during one of which they very nearly scored. In fact, if it was not for their weak shooting Welton would have been tried many times. Guy's made victory certain when Stebbings scored off a centre by Williamson, making the result, as stated above, 2 goals to nil in Guy's favour. Team :—

GUY'S.—Sharpe, A. C. M. Coxon, H. V. Stebbings, G. P. Lindsay, G. C. Williamson (forwards); L. Gill, D. A. Bevis, C. A. E. Cook (halves); J. Kyle, E. S. Phillips (backs); F. E. Welton (goal).

GUY'S v. OLD OWENS.

On Saturday, January 24th, Guy's went down to Oakleigh Park to play Old Owens. The frost had rendered the ground almost unplayable, the ball being extremely difficult to control and the ground being very dangerous to fall on, as was made very evident when Stebbings, in scoring his second goal, slipped over and gave his head a severe knock. However, Guy's turned up in full strength and were rewarded with a decisive victory of 7 goals to 1. Old Owens for the first quarter of an hour played one man short, but all through the game they never really became dangerous. Owing to the difficulty of controlling the ball Guy's found it very hard to shoot, but Lloyd was eventually successful with a good cross shot into the corner of the net. Old Owens then made one or two attempts at our goal, but a good clear from Kyle gave Williamson an opportunity to get through with the help of Coxon, from which he scored. In the second half, except for one or two rushes, during one of which they scored off Cook's head, Owens fell away considerably. Williamson again got away and scored. Coxon and Evans also obtained one each, and Stebbings gained two—one from a corner and the other just on time. Team :—

GUY'S.—J. A. E. Evans, Lloyd, H. V. Stebbings, A. C. M. Coxon, G. C. Williamson (forwards); L. Gill, D. A. Bevis, C. A. E. Cook (halves); J. Kyle, E. S. Phillips (backs); F. E. Welton (goal).

Death.

GARRETT.—G. W. B. Garrett, at a Nursing Home in Huddersfield, from pneumonia, after a short illness.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

CONSEQUENT upon the dissolution of the London Post-Graduate Association, the Medical School is once again free to organize special classes in, and devote a part of its energy to, post-graduate instruction. We publish elsewhere in this issue a syllabus of the various courses open to post-graduate students. As will be seen, post-graduate work is available in pathology, actino-therapeutics and radiology, public health, physiology, and general clinical work. In addition, special courses are provided for the Primary and Final Examinations for the Fellowship of the Royal College of Surgeons.

We publish a time-table of the course for the Final F.R.C.S., to which we would especially direct the attention of those men who are contemplating taking the examination. The course is a very complete one, and every aspect of the subjects necessary for the examination will be thoroughly dealt with.

The time-table has been arranged very carefully with a view to consolidating the work as far as possible, so as to leave those attending regular times and days for reading. All the classes will be held between 2 and 6 p.m. on four afternoons a week. Thus the times of attendance are regular and easily arranged for, and the mornings are left free for reading or clinical work. Anyone who has attended any special course in which one class was held at 10 a.m. and another in the afternoon will appreciate the benefit of a uniform time-table.

WE also publish a revised syllabus for the Entrance Scholarships offered for competition in September. The chief change is that two Senior or University Scholarships are now available in place of one as in previous years, and only three Junior Scholarships, one in Arts, one in Science, and the third in either Arts or Science as the merits of the candidates may determine. This rearrangement is, we think, more equitable, and should increase the competition for these awards.

THE sale of Christmas Greeting and Postcards of the Hospital realised last year the very respectable total of £18 1s. 10d. As in previous years, Messrs. Ash & Co., Ltd. very generously supplied the cards free of charge with the result that the whole of this sum reverts to the funds of the Hospital. The Hospital thus receives a very acceptable little Christmas present as the result of Messrs. Ash's kindness and the loyalty of the nurses and the men.

THE secretary or organiser of any form of activity in the Hospital finds it a wearying business constantly endeavouring to stimulate his supporters to show a little more enthusiasm for his particular speciality. Of course, some sections always have, and always will have, more difficulty than others, but the lot of the

Chapel choir at present seems to be peculiarly hard. We publish elsewhere in this issue a notice from Mr. Denis Browne, the organist in the Chapel, appealing for more support. We have heard the same tale from other quarters for some time past, and trust that this present poverty is only a very temporary matter which will soon be overcome. There must be plenty of men, well able to sing, who could easily turn up on Sundays.

We would direct attention to a letter from the secretaries of the Musical Society, which appears in our Correspondence columns. They also are appealing for more keenness on the part of singing men in the Hospital.

Quite recently, owing to the resignation of Messrs. Lee & Maxted, both Ophthalmic Registrarships have fallen vacant. Mr. Lee, as we noted a few weeks ago, has been appointed Ophthalmic Surgeon to the Leeds Public Dispensary, and Mr. Maxted has just been appointed Assistant Surgeon to the Norwich and Norfolk Eye Infirmary, Norwich. Messrs. C. M. Ryley (Mr. Eason) and J. S. Bookless (Mr. Ormond) have been appointed to the vacant posts. We congratulate all four gentlemen.

We have also to congratulate Mr. E. G. Schlesinger, F.R.C.S., on obtaining a British Medical Association Research Scholarship.

The next meeting of the Debating Society will be held in the Smoking Room on Saturday, February 21st, at 8 p.m. The subject for debate is "That modern fashions are decadent." Messrs. Sampson and Martin are supporting this view, and Messrs. Barber and Maxwell opposing it. Mr. A. R. Thompson will be the chairman for the evening. It is to be hoped that there will be a good attendance of members and that they will not be afraid to speak.

This is the time of year during which the Hunterian Lectures are delivered annually at the Royal College of Surgeons in Lincoln's Inn Fields. We notice that Professor Arthur Keith is giving a course of six lectures on the evolution, anatomy, and physiology of the anthropoid apes. They are announced for Mondays, Wednesdays, and Fridays at 5 p.m., commencing next Monday, February 16th. Morphology, especially as interpreted by Professor Keith, is a fascinating subject in itself, well worthy of a little attention even as a hobby; it is also daily assuming a more practical aspect. If we may take the questions set in the anatomy paper at the last primary examination for the fellowship as a guide, the student will shortly be expected to have at least a bowing acquaintance with the subject. Professor Wood Jones is also to deliver two lectures on the morphology of the external genitalia, on March 4th and 6th.

The thirtieth Dinner for Oxford and Cambridge men at Guy's will be held at 7.45 p.m. on Thursday, Feb. 26th, at Pagani's Restaurant. Tickets, price 4s. 6d., to be obtained from J. G. Saner and C. P. Symonds, hon. secs.

We have received the following gem from an O.P.O.:—

Aviation in the Borough.

". . . and that scar on my knee, doctor, was when I was operated on in Charity ward for a broken propellor."

Ralph Wingent Memorial Fund.

SECOND LIST OF SUBSCRIPTIONS.

	£	s.	d.
H. O. Brookhouse, Bromley, Kent	1	1	0
H. S. French	1	1	0
C. H. Golding-Bird, Meopham, Kent ..	1	1	0
"Guy's Student"	0	2	6
A. E. Lees, Knutsford, Cheshire	0	5	0
Henley Munden, Ilminster, Somerset ...	0	10	6
Mintern Munden, Chalford, Glos.	1	1	0
P. S. Price	2	2	0
E. G. Schlesinger	1	0	0
A. Tilbury	0	2	6
Fredk. Tooth	1	1	0
	9	7	6
Previously acknowledged	5	3	0
Total	£14	10	6

February 7th, 1914.

H. C. MANN,
P. S. PRICE,
Hon. Secs.

An Introduction to the Study of Comparative Anatomy.

A Lecture delivered at Guy's Hospital on Wednesday, January 21st, 1914,

By PROFESSOR UNDERWOOD.

Gentlemen,—I do not know whether Mr. Hopson was quite aware of what a treat he was planning for me when he invited me to address you to-night. I am very fond of talking; I am very fond of talking to you, and I am very fond of talking about comparative odontology. So that I have several pleasures rolled into one.

It is a curious fact that thirty years ago I delivered the first lecture I ever delivered on this subject, and among my audience then there were three members of that tribunal which I may describe as "The Four Just Men." One of those four just men was not present, and he was Mr. Hopson. They were students in that first course of lectures that I delivered. The fact of Mr. Hopson's brilliant attainments afterwards seemed to show that those lectures did not select the absolutely front rank, but selected three out of four.

If you will allow me, I am proposing to-day to be a little discursive. I am proposing to talk rather of the interesting side of comparative odontology than to endeavour to fill your minds with a mass of detail. I am bound to confess, in regard to detail in this subject, such detail as formulæ, that I find it easier to write a book upon the subject and refer to that when I want to talk about it, because I cannot carry these things in my head, and I do not think it is good for anyone to carry formulæ in their head. They have to do it, of course, when they are going up to meet the Four Just Men, but it soon slips. In fact, to-day I was wondering a little bit about some formulæ, and I thought that discretion was the better part of valour, and as I did not quite remember them, and had not my own book to refer to, I would say nothing about them.

This subject of comparative odontology, I think, stands to the rest of our studies somewhat as romance stands to our daily life. Our daily life is a stern business; we have got to earn bread-and-butter; we have got to do a lot of things which are distasteful and painful. When we creep away from that to our study, or to our laboratory, or to our museum and begin to look at comparative odontology, we enter a world of romance. It is also a world of history because it is the greatest history of all; it is the history of all humanity. We note little differences, we see little changes, and from those we deduce and infer and build up a history of our own past, or rather, of the past of our own ancestors. Remember this, please, that we are always liable to error; we are always re-editing our books. In fact, there is nothing that fills one more with shame than the perusal of one of one's own books after ten years. The reason of this is that the beginning of it we do not know about, the end of it we do not know anything about. We are like people looking down a side street at a procession. We note the procession passing at the end of the street, and we form our conclusions. Other people come and look at the procession, and they form their conclusions. And the series of spectators write their conclusions down, and, in the end, these things are put together and something like a connected narrative is arrived at. Please remember, also, in all discussions with regard to this great subject, that nature does not concern itself with rules. Mr. Hopson and I make rules; we make classifications, we divide things up, we give them names. But nature does not care a bit about that. Therefore, very often we have to revise our classifications and our names. Remember, also, that the process of evolution, for that is the process upon which all this learning is based, is a gradual process of improvement. But that improvement is not a direct and flowing improvement, it is generally in the nature of two steps forward to one step back. It is always ending in the creatures becoming rather more fitted for those surroundings in which they are placed.

Now, it is also a great movement from equality to inequality. We often hear it said that all men are equal, and that one man is as good as another. That is sometimes said rather unpleasantly to us. Now, as a matter of fact, all protamœbæ are equal as far as we can see. Chimpanzees are very equal one to another; but man is greatly unequal; and as we go up the tree of greater and greater improvement the inequality becomes more obvious. And it is well to note that the inequality becomes more obvious when the weapon of conflict is no longer the teeth or the claws, but the brain. It is when that comes into action to decide which is the fittest to survive that the inequality becomes the more glaring. It is also noticeable in the genea-

logical tree of humanity, dating back as far as we can, and filling gaps as far as we can by inference; it is also noticeable that the difference between the sexes becomes more obvious and more marked as the race progresses towards improvement, towards its higher state. In early stages in plant life we find androgynous things; we find both sexes combined in one individual. In the amœba there is no such thing as sex; it reproduces itself by subdivision. As we go up the genealogical tree, we come to animals in which the sexes are divided, male and female. We also have hints, as you always get, of what has gone before in the embryonic life of the individual, hints in the early stages of mankind, of a time when the sexual development might end either one way or the other. As the creature gets to higher perfection, so the sexual difference and the sexual function becomes more marked; until we come to a last stage—if I may call it so—when, on the one side we find the aberrant creature the chimpanzee, when it wandered off the main line a little bit, and here, at a little distance, it is rather hard to tell male from female. But I do not suppose anybody, who could see objects at all, would be in any difficulty to decipher male from female in the human being. These distinctions became more enforced as the race proceeds towards improvement, and their functions also became more entirely differentiated. I mention this fact because it is an anatomical fact beyond all dispute, and it has a somewhat interesting bearing upon the attitude of some of the representatives of the female sex to-day who seem to think that functions may now be shared.

I want to talk to you about two or three things, for I have to pick and choose, having little time. And I thought it might interest you to have a sort of practical answer to the question which is often asked, What is the use of all this comparative anatomy? Why should we have to learn it? The things which do you good, you know, the things which make you better men—and, incidentally, better dentists—are not the things the use of which is glaringly apparent. You wander into a by-path, you find out a fact, you study it, and suddenly its application comes. A little time ago I was forced by circumstances to observe the anatomy of the maxillary sinus in very many animals and in the human being. Professor Keith allowed me to examine many skulls with this object, and, to my astonishment, I found that what I had always learned and taught with regard to this sinus was not all correct. I found that there were very many things which I had never dreamed of with regard to the anatomy of the

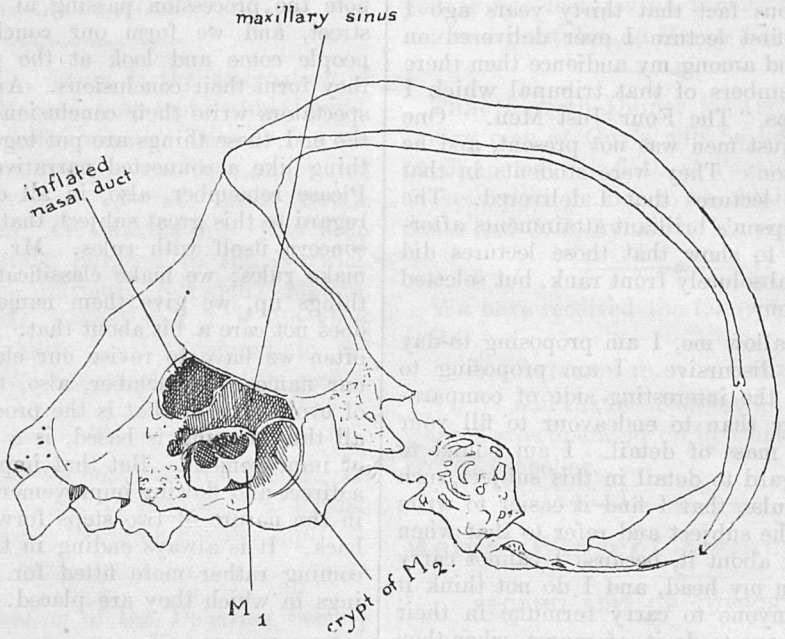

FIG. 1.

face, and which had not been put down in books. I obtained a great many drawings of these various antra, and it may interest you to learn that these drawings, which were made by my wife, have never been shown before. You will be able to judge for yourselves, but they are very nice drawings, and they require such an enormous sum to reproduce that they have not been shown before, except to a few friends, and I am proposing, for the first time, to show them to you now. I will ask the epidiascope operator to show them, and I will describe them as we go along.

This is of a baby gorilla (fig. 1), and the interest of this specimen, from which the outer piece of bone covering the antrum has been removed, is to show that this cavity, the antrum, exists as a nursery for developing teeth. It has no other functional reason for its existence. You see the teeth formed in their crypts, and occupying practically the whole space, and descending not in a great vertical line, but one behind and above the other. And gradually, as they get into their position, the bony crypts which cover them sink after them, and eventually there is formed the cavity which we know as the antrum. It exists for the teeth. And what is very interesting—I do not know whether I have a picture to show it you—is that, like the alveolus, which, you know, is formed to hold the temporary teeth and removed after they are lost, and again formed for the permanent teeth, the antrum is formed to be a nursery for the formation of the teeth, and when they are lost the antrum is filled up. That is a thing which, I think, had not been observed until I had the good fortune to observe it.

This is a section of a gorilla (fig. 2). The point which it is interesting to draw attention to is the frontal sinus, which is not very large, but is larger than the frontal sinus of the orang; here is the sphenoidal sinus, and here the commencement of a sinus which in the chimpanzee is largely developed into the supra-palatine sinus, which I had the honour of first describing.

This is a gorilla, and the main interest is that it looks as if it had two antra; but the posterior big cavity is the antrum, and the other is a dilatation of the nasal duct. All these cells have a reference to sound, and this animal in a state of excitement, probably sexual excitement, utters a noise for which this large nasal duct may be useful.

Here you see another baby chimpanzee, and it shows the beginning of this supra-palatine

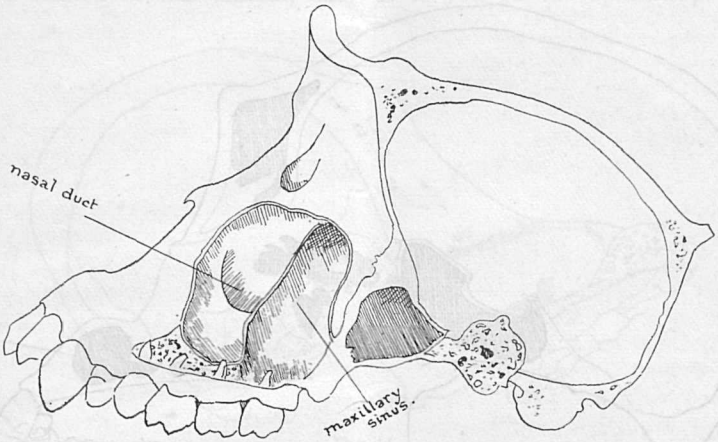

FIG. 2.

sinus, which is a big affair compared with what it was in the gorilla which I showed you. This is an immature individual, and you see there is no frontal sinus and very little sphenoidal sinus. There is very little sinus in it at all at this stage.

Here is a big chimpanzee (fig. 3). In order to be sure about the noise these animals made in reference to their air cells I went into their cage at the Zoological Gardens, in great fear and trembling, guarded by Mr. Pocock, and the chimpanzee made infinitely more noise than did the orangs. There is an immense frontal sinus, and you see the supra-palatine sinus, which stretches below the nasal tract, and above the palate roof, right across. On the other side it is interrupted by an imperforate septum. You see this upper canine. If you can trace it in imagination you will see its root more curved; and at the Natural History Museum I ask you

to look at the gorilla, its upper canine is very much curved.

The next (fig. 4) is mainly interesting as showing these air cells, practically filled with more or less cancellous bone; it is an orang. Pycraft in his book says it makes a loud noise, but I have not heard it; they seemed to be trying to do so when I observed them.

So much for the antrum. Now, I want to impress upon you the relation of the face and cranium, and this is comparative. Remember, comparative anatomy is not the anatomy of any one species, but comparing one thing with another.

[The lecturer here drew a series of profiles to illustrate prognathism, and a series of coronoid processes to illustrate the changes of shape in this process when the "temporal," "masseter," and "internal pterygoid" muscles were specially developed.

He also showed some radiographs of the Piltdown mandible which demonstrated that the individual was certainly adult, indeed, late middle age, because of the degree of wear of the surface of the two existing molars; that the third molar which had been lost after death had fully developed sockets with perfect alveolar divisions and could not possibly have been, as had been suggested, in process of eruption. That the canine was obviously mandibular was shown by the shape of the root which could not be fitted into a prognathous maxilla without sticking out above the surface. The suggestion that the molars were those of a chimpanzee was hardly worth discussing, there was sufficient evidence in the enamel alone to dispose of that; moreover, the canine itself was easily distinguishable from that of a chimpanzee. The shape of the under surface of the symphysis necessitated procumbent incisors and a railed canine. These points were fully demonstrated by a comparison of the Heidelberg mandible with that of modern man, the Piltdown fragment, and chimpanzee on the epidiascope.]

And now I want to say a word about that faculty which I am displaying so fully to-night, the faculty of speech. Really, it is speech, more than anything else, which cuts us off from our remote cousins. No doubt they have a sort of speech, but we have, as you have noticed to-night, a very great deal. Anatomically we are able to say how much speech a creature has if we can see its mandible. As a matter of fact, looking at this chimpanzee from below we should find that there is very little room for the muscles which go from the hyoid bone to the tongue, and what I still persist in pronouncing the genial tubercles, though I know it is wrong. Those muscles have very little room and very little play. In the Heidelberg man we find there is more room, but his mandible is very thick. When we come to modern man we find that space is vastly increased. There is the mylohyoid ridge and there is plenty of room for free movement of the muscles of the tongue. What I should like you to do is to go over some

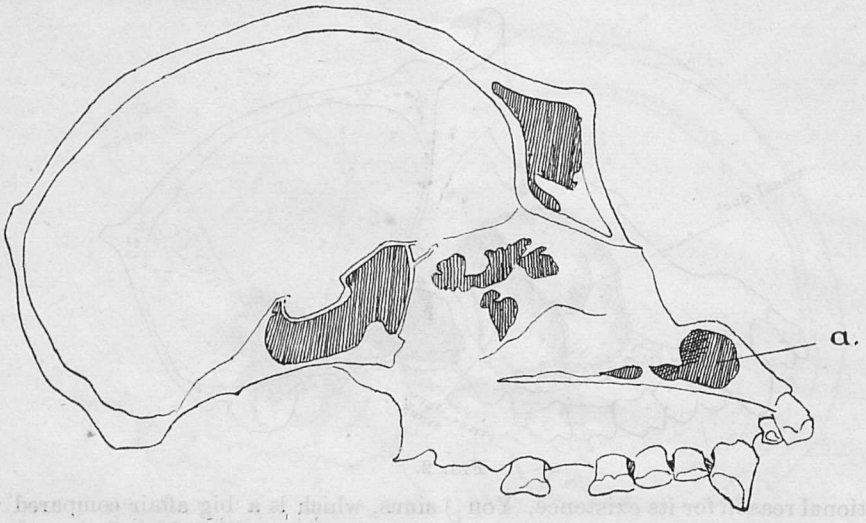

FIG. 3.

of these little points that I have hastily and discursively suggested to you in your Museum, or, perhaps, even better, in the Museum of Natural History in Cromwell Road. Take a skull in your hand and look at it, and see what room there is for the muscles of mastication. If you take the maxillary part of an animal and look at the places where you would expect to find pterygoid plates, you can tell exactly whether he is using the external pterygoid or not, or whether he is moving sideways or not, and if his molars were destroyed you could make them again for him; you could be as certain of what his molar series were as if you had them placed before you.

Here is a beautiful mandible from your Museum. You see this chin pronounced and distinct. That is because the necessity for biting, which once existed in this animal, has gone away, and so the alveolar process has run back. The whole building up of a jaw or any other part is a continual plastering on and taking off. Sometimes it is necessary to take off more. In this case the alveolar process has been forced back, leaving the chin standing out for the attachment of muscles. And that was not the case in the ape, it was not the case in the Piltdown fragment.

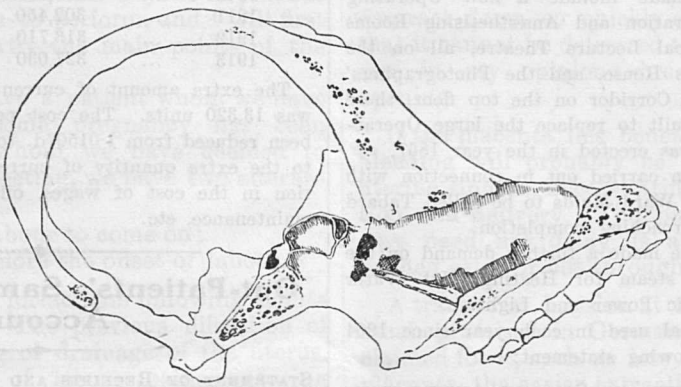

FIG. 4.

And now, to conclude, gentlemen, let me say this. I have known a great many pleasures, but I have never had a pleasure in my life quite to equal the pleasure of first noting an anatomical peculiarity. I can assure you the joy of finding that supra-palatine sinus, to which I have alluded, in the chimpanzee was simply a pleasure such as nothing else can equal. And, mind you, those pleasures are all to your hand. Because this is my experience, and I believe it is Mr. Hopson's and everybody else's; we copy things from book to book; we get weary and sick of them; we hate the old pictures and the old diagrams which we find in all ordinary books. We get hold of some name which has been to us only a name. We rush for the specimens and we get them down and we differ from the authority. That is where the birth of the delightful interest is that holds you a slave to the end of your life. Once you have begun to see something in these specimens which somebody else has not seen you are a slave for life, but it is a delightful slavery, and I hope to goodness that among my audience to-night there are many present who will one day be standing where I am and saying, "Years ago I heard old Underwood say this, that, and the other, and it is all wrong, and I shall prove it to you on the epidiascope." I am awfully grateful to you for having listened to me so attentively.

Mr. DOUBLEDAY proposed a hearty vote of thanks to Professor Underwood for delivering the lecture. He had placed all dental students under a debt for his magnificent text-books which he had written for their benefit, and many a poor candidate trembling at his *viva voce* had reason to bless him for them. But they at Guy's had not previously had the opportunity of thanking him personally, and on this occasion they possessed that privilege.

Mr. HOPSON said he asked the Professor to come because they had been working at the subject rather more than three months and were becoming a bit jaded, and he thought that if Professor Underwood would come and put cer-

tain facts in a new light it would stimulate interest and cause them to go forward. He always liked to regard himself as a sort of grandson, because all his dental teachers were sons of that School in Leicester Square, for the honour and fame of which Professor Underwood had done so much.

Prof. Underwood: It is difficult to answer such a kindly sentiment as has fallen from Mr. Doubleday and Mr. Hopson, and fallen in such great tolerance from you. The only thing I can say is, Will you let me come again?

Extracts from the Consulting Engineer's Report for the Year 1913.

The additions and alterations during the past year which have been made include a new Operating Theatre, with Preparation and Anæsthetising Rooms adjoining, and Clinical Lecture Theatre, all on the second floor of Guy's House, and the Photographers' Studio, Balcony, and Corridor on the top floor, these rooms having been built to replace the large Operating Theatre which was erected in the year 1867.

Work has also been carried out in connection with new quarters for the Ward Maids to be called Tabard House. This is approaching completion.

These addition have made a further demand on the Central Station for steam for Heating, Hot Water Supplies, and Electric Power and Light.

The amount of Coal used in each year since 1904 is shown by the following statement:—

Summary of Coal used and Cost per Annum since 1904.

Year.	Tons.	Total Cost. £ s. d.
1904 ...	4,887 ...	3,867 8 0
1905 ...	5,192 ...	3,867 2 1
1906 ...	4,784 ...	3,576 3 11
1907 ...	4,774 ...	3,998 2 5
1908 ...	5,132 ...	4,668 10 0
1909 ...	4,824 ...	4,073 19 6
1910 ...	4,437 ...	3,665 7 10
1911 ...	4,456 ...	3,694 4 2
1912 ...	4,641 ...	4,217 3 9
1913 ...	4,984 ...	4,993 14 3

It will be seen from this statement that during the year 343 tons more coal has been used than in the previous year. In the previous year heat was, as far as possible shut off in the Hospital in order to economise coal during the coal strike, the third boiler being shut down in 1912 on February 28, whereas this year the third boiler was not shut down until April 24th.

The cost for coal is £776 more than in the previous year. This is due to the increased price of coal which, as stated in my report for 1912, is indirectly the result of the labour unrest of last year.

Electric Light and Power.

During the year 80 lights and 40 electric lighting plugs have been connected. Including these the actual number of lamps now in use in the Hospital is 4,823 and 1,200 plugs.

In the new Clinical Lecture Theatre referred to above, a n electric motor-driven fan for heating and ventilation purposes has been installed.

During the year three miles of ordinary insulated wire and one mile of lead-covered wire have been used to carry out the extensions and alterations which have been made.

Summary of Electricity used and Cost per Annum since 1905.

Year.	Units of Electricity used in the Hospital.	Cost per Unit (exclusive of Interest and Depreciation.
1905 ...	237,303 ...	1·458d.
1906 ...	246,504 ...	1·3258d.
1907 ...	296,320 ...	1·16562d.
1908 ...	317,611 ...	1·1093d.
1909 ...	315,671 ...	1·03481d.
1910 ...	300,660 ...	0·97883d.
1911 ...	302,450 ...	0·98484d.
1912 ...	313,710 ...	1·01507d.
1913 ...	327,030 ...	1·00526d.

The extra amount of current used during the year was 13,320 units. The cost per unit for current has been reduced from 1·01507d. to 1·00526d. This is due to the extra quantity of current supplied, the reduction in the cost of wages, oil waste, stores, repairs, maintenance, etc.

Out-Patients' Samaritan Fund Account.

Statement of Receipts and Expenditure for the Twelve Months ended December 31st, 1913.

RECEIPTS.

1913.		£ s. d.	£ s. d.
Jan. 1.	To Cash Balance brought forward from last a/c ...	4 8 4½	
	To Donations	4 8 0	
			8 16 4½
			£8 16 4½

EXPENDITURE.

1913.		£ s. d.	£ s. d.
Jan. 1.	By Surgical Appliances...	1 13 1½	
	Clothing, etc. ...	0 7 6	
	Patients' Fares, etc...	2 3 5	
	Sundry Expenses ...	0 12 7	
			4 16 7½
	Balance carried to next a/c		3 19 9
			£8 16 4½

Audited and found correct,
(Signed) CHAS. H. WELLS,
January 19th, 1914. Incorporated Accountant.

Cæsarian Section.

CLINICAL LECTURE BY G. BELLINGHAM SMITH.

November 17th, 1913.

Gentlemen,—In this lecture I shall consider some of the indications for Cæsarian Section. By Cæsarian Section is meant the removal of the fœtus by means of incisions made through the abdominal and uterine walls. Within my own experience this operation, from being one rarely employed and then only in cases in which the child could not be delivered through the pelvis, has become one of comparatively frequent performance with a much wider range of indications. This is due to the improvements in aseptic surgery, the mortality in favourable cases being reduced almost to nil.

This is an operation that anyone in practice may be called upon to perform, and I will first of all consider shortly the main points of the operation.

Supposing we have a patient whom we have seen before full-time pregnancy has been reached and on whom we have decided to perform Cæsarian section, we have two alternatives—

(1) To wait for labour to come on;
(2) To operate before the onset of labour.

In favour of the former the following points have been urged:—The previous dilatation of the cervix allowing of drainage of the uterus, and the presence of labour pains ensuring contraction of the uterus. As regards the latter, experience shows that the uterus contracts well when operation is undertaken before the appearance of labour pains. The only uterus that will not contract is one exhausted by labour. The presence of a dilated cervix, again, does not appear to be of practical importance. There may be some temporary retention of clots, but dilatation soon comes on and they are expelled.

As a third alternative it has been suggested that labour should be induced by means of bougies to ensure dilatation of the cervix. I have no hesitation in saying that this should be strictly avoided, as should all vaginal manipulations.

In favour of the second alternative, namely, to operate before the onset of labour, we have three important points: The patient can be properly prepared for operation; arrangements can be made for the operation and for procuring adequate assistance; and the operation can be performed at a suitable time, arranged beforehand, instead of being hurriedly called for at any time day or night.

The Operation.—The preliminary preparations are those of any abdominal operation and need not delay us. An incision is made through the abdominal wall about seven inches long, and is carried down to within three inches of the pubes. This will mean that from one-third to a half of the incision is above the umbilicus. Be careful when continuing the incision downwards that the bladder is not wounded. The uterus is incised *in situ*. An opening of about three inches is made through the wall of the uterus to its inner surface, and with the fingers as directors is prolonged upwards and downwards till it is quite six inches long. It is important that this opening should be of sufficient size to allow of easy and rapid delivery of the child's head. Cases in which the uterus is said to contract down so quickly on the child's head that it cannot be delivered through the wound, are, in my opinion, due to an inadequate opening.

If the placenta lies beneath the incision the bleeding will probably be very free from the uterine sinuses, necessitating rapidity in operation and delivery. The placenta lying in the way need not delay us as it can either be pushed aside or cut through.

A transverse incision at the fundus has been much practised in Germany. The advantages claimed for it, such as less risk of incising the placenta, the easier extraction of the child, and the greater contraction of the wound after delivery of the child, are more theoretical than real. I advise the older method I have described with the longitudinal incision corresponding to the wound in the abdominal wall.

The child should be delivered by the leg. This is readily felt and seized when a hand is passed into the uterus. In some text-books I see that it is recommended that delivery should be effected head first on the grounds that the uterus will not then prevent the delivery of the after-coming head. I have already pointed out that this is not likely to take place if the incision is large enough. Moreover, the head is not easy to grasp.

The child having been delivered and the funis tied, is handed to someone fully competent to attend to it. This is very important, and should never be neglected. Inattention to this detail may result in the loss of the child.

The cord having been severed the uterus is turned out of the wound, a roll of gauze being packed into the abdominal cavity behind it. The placenta and membranes are carefully peeled off its interior, hæmorrhage being controlled by an assistant who grasps the uterus firmly around its lower segment, compressing the broad ligaments against the uterine wall.

An assistant should by this time have a number of sutures either of catgut or of silk threaded on large fully curved or straight needles. I have, so far, used catgut with satisfactory results. The sutures are inserted at intervals of about three-quarters of an inch, being so introduced as to emerge and enter the cut surface at its junction with the mucous membrane. Either a continuous gut suture or interme liate ones then co-apt as accurately as possible the cut peritoneal edges of the wound.

Extra-peritoneal cæsarian section is an operation that has been devised and carried out. I shall not do more than mention this operation, as I see but little to recommend it. It is more difficult to carry out, post-operative complications are numerous, sepsis is common, and the risk of death from peritonitis appears to be as great as in trans-peritoneal cæsarian section.

Indications for Cæsarian Section.—The first indication to mention, and the commonest, is some contraction of the pelvis, the usual forms being the flattened pelvis, where the conjugate vera is diminished in size, and the generally contracted where all the diameters are less than normal.

Now it is clear that the amount of difficulty met with in any case will depend upon the relative proportions of the pelvis and the child's head. There are a few measurements in connection with flattening of the pevis that may be usefully borne in mind as indicating the difficulties likely to be met with at full term with a child of what we may describe as average size.

Thus, when the true conjugate is below two and a half inches a child cannot be extracted through the pelvis ; it must be delivered by Cæsarian section, and this we describe as the absolute indication for this operation.

Between two and a half and three and a quarter inches we shall not get a living child through the pelvis unless it is small. It will have to be delivered by some such operation as craniotomy. Above three and a quarter inches a living child can be born at term with or without assistance.

With a generally contracted pelvis, owing to the involvement of all the diameters, the above measurements do not apply. Pelvimetry under these circumstances gives us a much less clear indication of the possible difficulties likely to be met with at full term than is the case with a flattened pelvis, and we have to rely to a much greater extent upon an estimation of the relative sizes of the pelvis and the child. This I shall refer to later when considering the induction of labour.

As regards treatment in a case of contracted pelvis, we have four alternatives where assistance of some kind other than that afforded by the forceps at full time is required :—

(1) Cæsarian section.
(2) Induction of labour.
(3) Craniotomy.
(4) Pubiotomy.

I will take, first of all, the last mentioned, namely, *pubiotomy*. In this operation the bone is divided either by open wound or subcutaneously to one side of the symphysis, and has replaced the older operation of division of the symphysis—symphysiotomy. It has been widely practised of late years, though less in Great Britain than elsewhere. It may be said to add about half an inch to the conjugate, and is consequently of use in medium degrees of contraction, the child being subsequently extracted with forceps through the pelvis. Its range of utility is limited, and is practically confined to cases of flattened pelvis in which the conjugate vera measures between three and three and a half inches. As the result of their division the bones in front spring widely apart, and in the extraction of the child this lack of support to the parts in front, including the bladder, involves an increased risk of injury. The mortality is said to be from 4 to 6 per cent., but I do not lay stress on this, as I do not quite know the condition of the cases operated upon. The most serious objection to this operation lies in the complications. The following are common :—Severe tears of the soft parts, injuries to the bladder, hæmatoma, more or less sepsis, and later on hernia through gaps in the bone, prolapse of vaginal walls and chronic incontinence of urine. Further, convalescence is prolonged, and in my experience of cases seen, patients are often months before the pelvis will bear the weight of the body

In consequence of its limited range, and more particularly the very large morbidity of this operation, I prefer to confine myself to other lines of treatment.

Let us take the case of a patient with a contracted pelvis and consider what we shall do under varying circumstances.

Cases seen early in pregnancy.—We will assume first of all that we have the patient brought to us early enough in pregnancy to decide upon any procedure that seems to be the best. Taking the case of a flattened pelvis we first of all estimate the size of the conjugate, and then decide on the procedure to be adopted.

1. With a conjugate below two and a half inches we have no choice, unless the case is seen sufficiently early in pregnancy to allow of the uterus being cleared out. We shall have to empty the uterus by Cæsarian section at full term.

2. With a conjugate of two and a half to three and a half inches we have a choice of Cæsarian section or *induction of labour* some time before full term.

The child is viable after the twenty-eighth week of pregnancy, and consequently induction performed any time between then and the termination of pregnancy offers the chance of a living child. The smaller the pelvis within the above limits the earlier induction would have to be brought about, and the less the chances of getting a living child.

With a pelvis for instance of two and three-quarter inch conjugate we should have to induce about the twenty-eighth week.

It is found in practice that when the conjugate is below three and a quarter inches (two and three-quarter to three and a quarter inches) the fœtal mortality with induction is so high, being 53 per cent., that it seems scarcely worth while to advise it unless the patient or her friends refuse Cæsarian section.

Above three and a quarter inches (three and a quarter to three and a half inches) induction is commonly practised, and may be recommended as the operation of choice. In this case the mortality of the child is reduced to 12 per cent.

Whilst measurements of the pelvis are valuable in the early stages of pregnancy as indicating the probable choice of treatment, they do not take into consideration another factor—the size of the child's head. They are estimated for a fœtal head of average size. Now children vary greatly in size, and consequently our treatment may have to be modified somewhat when we are dealing with a child much below or above the normal size. The child's head cannot be measured, but we can estimate roughly the proportions that the child's head and the pelvic brim bear to one another by noting the ease with which the head can be pressed into the pelvic brim. This applies more particularly to the small round pelvis, where pelvimetry gives us less secure indications for treatment than in the flattened pelvis, but it should be employed in all cases. In practice we generally see the patient about the seventh month of pregnancy, and note the ease with which the child's head can be pressed down into the pelvis. She is then seen at intervals varying according to the relative sizes of the child's head and the pelvic brim. When the time arrives at which the head can no longer be pressed easily into the brim, induction should be started. It may be advisable at this stage to give an anæsthetic to relax the soft parts. The left hand is then placed on the head externally, whilst one or two fingers of the right hand estimate the amount of descent of the head into the pelvis. As Dr. Barbour has said, "The fœtal head is the best pelvimeter."

So that for a flattened pelvis with a conjugate measuring from two and a half to three and a half inches our choice would be Cæsarian section at full term between two and a half and three and a quarter inches, and induction of labour between three and a quarter to three and a half inches, our treatment being controlled to some extent by a careful examination from time to time of the relative sizes of the fœtal head and pelvis. In the case of a small round pelvis our treatment depends almost entirely on this latter mode of examination. Induction would, under the above circumstances, be carried out between the thirty-fifth and thirty-sixth weeks of pregnancy.

Cases seen at full time.—We now have to consider those cases of contracted pelvis seen for the first time at the end of pregnancy or in the course of labour. One thing we note at once and that is that induction of labour is no longer under consideration, and putting aside pubiotomy we are left with Cæsarian section and craniotomy. With a conjugate below two and a half inches we have as before no choice. The child must be delivered by Cæsarian section. Above two and a half inches our procedure will be determined by the possibility or not of some septic infection having taken place.

If the membranes are unruptured, we are dealing with a presumably aseptic case, and if the child is alive Cæsarian section should be performed.

If the patient has been in labour for some time, the membranes ruptured, and attempts at delivery made with forceps, Cæsarian section becomes a much more dangerous operation owing to the risks of sepsis. It is in these cases that the mortality from this operation lies

almost entirely. Under these circumstances, if Cæsarian section is decided upon, we had better, after the delivery of the child, proceed to hysterectomy.

The only two cases I have lost have been those on whom I have performed Cæsarian section after labour had been prolonged and some instrumental interference had taken place beforehand. On one other similar occasion I performed hysterectomy and recovery was uneventful. There is no doubt whatever as to the serious increase of risk run by patients who have undergone previous attempts at extraction, and provided the child is alive and is delivered by Cæsarian section, although hysterectomy appears to be a serious undertaking, I have no doubt as to its advisability.

We have as an alternative to Cæsarian section the destruction of the child by *craniotomy* and its delivery through the natural passage. I have not mentioned craniotomy before; as a deliberate choice in obstetric practice it has no place. One would not advise a patient to go to full time and have the child destroyed. Its mortality is high and the complications in the shape of injury to the passage, bladder, etc., frequent.

Nowadays, with the more careful examination of patients beforehand, it is seldom performed. It may be called for—

(*a*) In general practice, when the facilities for Cæsarian section do not exist, and the conjugate is over two and a half inches.

(*b*) When the child is dead.

(*c*) When the patient is septic or is presumed to be infected. If little doubt exists as to infection, it would probably be safer to perform Cæsarian section followed by hysterectomy even if the chances of saving the child appeared doubtful.

Other indications than contracted pelvis.—I shall only be able to consider these very shortly.

Cæsarian section for fibroids.—Fibroids may give rise to various complications in pregnancy and labour, but it is only as a cause of obstruction that we need mention them here. The usual situation in which a fibroid threatens to or actually obstructs labour is low down in the posterior wall or in the cervix. Those in the anterior wall generally get drawn up in the course of labour.

With a fibroid in the pelvis threatening to obstruct labour, or actually doing so in the course of labour, Cæsarian section should be performed, and may be followed by myomectomy or hysterectomy. As regards these operations, time does not allow of any detailed discussion, but we should consider carefully the question of future pregnancies before removing the uterus.

Cæsarian section and cancer of the cervix.—In the case of a pregnant woman with cancer of the cervix, in the great majority of cases treatment would be considered with reference to the mother only. If cancer is discovered in the course of pregnancy, the uterus would be removed as soon as possible without any consideration being paid to the child.

If the patient is seen for the first time near full term, and the cancer appears to be operable, the best treatment appears to be Cæsarian section followed by pan-hysterectomy. The alternative treatment would be to allow labour to proceed and to perform hysterectomy at a later date. This is feasable in cases of very early carcinoma, but when it is at all advanced, difficulty may be met with owing to failure of the cervix to dilate, necessitating forcible dilatation or division of the cervix and the use of forceps or craniotomy for the delivery of the child. The bruising of the growth, the laceration of the cervix, and the already septic condition of the tumour together present a very grave risk for the mother. Where in any case the whole or greater part of the cervix is involved in growth, and more particularly where the cancerous growth is breaking down, the risk to the mother and to the child, if viable, are less in the performance of Cæsarian section and hysterectomy, than in allowing labour to proceed by the natural route. When the cancer is inoperable the difficulties of delivery will be enhanced. Cæsarian section will be necessary for the delivery of the child. Owing to the risk of infection of the uterus from the septic cancerous tissue, it would probably be advisable to remove the body of the uterus.

Cæsarian section for ovarian tumour.—This will only be required when there is an ovarian tumour in the pelvis obstructing delivery and which cannot be pushed up. Attempts to deliver the child by forceps or craniotomy are dangerous as leading to injury of the uterus or rupture of the cyst. The same thing may be said of attempts at tapping the cyst. If this has to be done as an emergency treatment, arrangements should be made to remove the cyst as soon as possible after delivery. The best treatment is to open the abdomen, when in most cases the tumour can be drawn up out

of the pelvis. If this is found to be impossible Cæsarian section will be indicated, the tumour being dealt with after the uterus is emptied. With regard to the routine performance of Cæsarian section, when the abdomen has been opened for the removal of an ovarian tumour, practice differs, and it is not possible at present to lay down any hard and fast rule. Certainly the completion of labour presents many advantages both for the patient and the surgeon.

Other conditions causing obstruction and calling for Cæsarian section.

1. Pelvic tumours other than those described already.

2. Cicatricial contraction of the cervix and vagina, the result of sloughing following previous difficult confinements.

3. Previous ventro-fixation of the uterus. We have had, I think, two examples of this in the hospital.

4. Tonic contraction of the uterus. If the patient's condition allows of it, I shall not hesitate in future to empty the uterus by the abdominal route and remove if necessary the uterus. The difficulties and dangers of extracting the child by the natural passage can only be appreciated by those who have had to deal with many of these cases.

5. Cases of missed labour. These are excessively rare. I had one case recently in the wards which was successfully dealt with by Cæsarian section. The uterus was left, there being no obvious indication of septic infection.

Cæsarian section for placenta prævia.—This operation is extremely rarely indicated for placenta prævia. As a routine operation it can, at present at all events, have no place. There are only two clearly-marked indications for its performance: when the cervix is rigid and undilatable, and when the life of the child is of great importance, provided that the patient is near full term and the child is alive.

Cæsarian section for concealed accidental hæmorrhage.—This may be called for in severe cases when there is evidence that continued bleeding is taking place into the uterus and the patient is becoming collapsed. The decision as to when to operate is undoubtedly very difficult. Many cases do very well with vaginal packing and a firm abdominal binder. On the other hand, it may well happen that, simpler measures having been tried and having failed, the collapse of the mother renders the operation a forlorn hope. I think it may be said in favour of routine Cæsarian section for concealed hæmorrhage that it can be undertaken in most cases before the condition of the patient is desperate, and that it allows of the uterus being removed if it fails to contract properly after its contents have been taken out.

Cæsarian section and eclampsia.—This subject is too difficult to allow me to make any attempt at dealing with it adequately. I will remind you, however, that emptying the uterus by vaginal Cæsarian section has met with a fair measure of success. On the other hand, abdominal Cæsarian section has met with uniformly bad results. I think the reason probably lies in the fact that abdominal Cæsarian section has usually been left as a final resource in treatment. I can see no reason why it should not yield the same results as when performed by the vaginal route, if employed as a routine measure and with the same selection of cases as governs the other operation. I am not now recommending it as the line of treatment I follow or advise you to follow, but it is possible that the future may show that it possesses advantages that cannot at present be claimed for it.

Appointments.

Military.

Brevet-Lieutenant-Colonel Edgar M. Pilcher, D.S.O., to be Lieutenant-Colonel, *vice* C. Birt, dated January 1st, 1914.

Civil.

B. R. Parmiter, M.B., B.S., has been appointed House Physician to the Hospital for Consumption, Brompton, S.W.

G. Maxted, M.D., B.S., to be Assistant Surgeon, Norwich and Norfolk Eye Infirmary, Norwich.

G. Dunderdale, M.D., B.S., Uganda Medical Service, to be M.O. in charge of Lamu and the Province Tanaland.

J. A. Delmege, M.R.C.S., L.R.C.P., D.P.H., to be Assistant County Medical Officer of Health for Hampshire.

H. Lee, M.B., B.C., F.R.C.S., to be Honorary Ophthalmic Surgeon, Leeds Blind Institute.

Pass List.

Indian Medical Service.

The result of the Competition for Commissions in the I.M.S., held recently, has been announced. The following was among the successful candidates:—

Gordon Covell, M.B., B.S. Lond., third place (3375 marks).

Notices.

Guy's Hospital Medical School.

COURSES OPEN TO POST-GRADUATE STUDENTS.

(Issued consequent upon the dissolution of the London Post-Graduate Association and additional to the General Undergraduate Teaching.)

1. DEPARTMENT OF PATHOLOGY:—

Experimental Pathology, P. P. Laidlaw, M.B.; Bacteriology, J. W. H. Eyre, M.D.; Clinical Microscopy, G. W. Nicholson, M.D.; Pathological Chemistry, J. H. Ryffel, M.B.; Morbid Histology, G. W. Goodhart, M.D.

A. In each of the three Terms of the year a Course of Instruction in Clinical Pathology is held, including daily instruction in Bacteriology, Vaccine Therapy, Clinical Microscopy, Morbid Anatomy, and Pathological Chemistry. Time-table on application. Fee for the three months' Course: 15 Guineas.

B. Graduates wishing to conduct special investigations, or to carry out work for Theses for the M.D. or other Degrees, may apply for permission to work in one or more of the Pathological Laboratories under the Head of the Department concerned. Fee for three months' special work: 10 Guineas. In approved cases this fee will be remitted.

2. DEPARTMENT OF ACTINO-THERAPEUTICS AND RADIOLOGY:—

Actino-therapeutics, C. E. Iredell, M.D.; Electric Treatment, A. F. Hertz, M.D.; Medical Radiography, W. Lindsay Locke, M.B.; Surgical Radiography, E. W. H. Shenton, M.R.C.S.

In each of the three Terms of the year Instruction in Actino-therapeutics, Medical Electricity, and Radiology is given, including instruction in the therapeutic uses of radium, X-rays, and electricity, and in the use of X-rays in the diagnosis of medical and surgical complaints. Time-table on application. Fee for the three months' course: 10 Guineas.

3. DEPARTMENT OF PUBLIC HEALTH:—

Bacteriology, J. W. H. Eyre, M.D.; Hygiene, R. King Brown, M.D., D.P.H.; Chemistry and Physics, H. Rogerson, M.Sc.

In each of the three Terms of the year Courses in Public Health are held, including instruction in Bacteriology, Hygiene, and Chemistry. Fee for the three months' course: 15 Guineas.

4. DEPARTMENT OF PHYSIOLOGY:—

M. S. Pembrey, M.D.; E. L. Kennaway, M.D.; G. Marshall, M.B., B.S.

A. In each of the three Terms of the year Courses and Advanced Work in Physiology (recognised for the Honours B.Sc. of the University of London) are held, and are open to approved Students without Special fee.

B. Graduates wishing to conduct special investigations or to carry out work for Theses for the M.D. or other Degree may work in the Physiological Laboratory under the Head of the Department. Fee for three months' special work: 10 Guineas. In approved cases this fee will be remitted.

5. SPECIAL REVISION COURSES FOR THE FINAL EXAMINATIONS FOR THE "CONJOINT" DIPLOMA AND FOR THE DEGREES IN MEDICINE AND SURGERY OF THE VARIOUS UNIVERSITIES:—

Medicine, H. C. Cameron, M.D.; Surgery, P. Turner, M.S.; Midwifery, H. Chapple, M.C.

Special Revision Classes in each of the Subjects for the Final Examination are conducted twice weekly during each of the three Terms of the year, during the two months preceding the Examinations in January, April, and July.

Fee for the Revision Classes, together with the right of admission to the clinical practice of the Hospital for three months, including instruction in the Wards and at Out-Patients, Demonstrations in the Post-mortem Room and Museum, and Clinical Lectures and Demonstrations: 12 Guineas.

6. SPECIAL REVISION COURSES FOR THE PRIMARY AND FINAL EXAMINATIONS FOR THE DIPLOMA OF F.R.C.S. ENG.

(A) Primary Examination. Physiology, E. L. Kennaway, M.D.; Anatomy, T. B. Layton, M.S., F.R.C.S.

Special Revision Courses, with daily tuition in Anatomy and Physiology, are held twice a year, beginning on the 1st September and the 1st March, and continuing until the Examinations in November and May, respectively.

Fee for each Course in either Subject: 5 Guineas.

For students who have paid an Entrance Fee to the Medical School, the fee for each Course in either Subject will be 2½ Guineas.

(B) Final Examination. Special course to commence on the 2nd March. Time-table:—

Monday, 2—3.30, Tutorial Class, A. H. Todd, F.R.C.S. 4—5, Clinical Demonstrations by the Surgeons and Assistant Surgeons. 5—6, Surgical Pathology, R. Davies-Colley, M.C., F.R.C.S.

Tuesday, 2—3.30, Tutorial Class, A. H. Todd, F.R.C.S. 4—6.30, Operative Surgery and Anatomy, E. C. Hughes, M.C., F.R.C.S., and Demonstrators.

Thursday, 2—3.30, Tutorial Class, A. H. Todd, F.R.C.S. 4—6.30, Operative Surgery and Anatomy, E. C. Hughes, M.C., F.R.C.S., and Demonstrators.

Friday, 2—3.30, Tutorial Class, A. H. Todd, F.R.C.S. 4—5, Clinical Demonstrations by the Sur-

geons in charge of Special Departments. 5—6, Histology, G. W. Nicholson, M.D.

Fee, £15 15s. For Students who have paid an Entrance Fee to the School, £12 12s.

7. CLINICAL CLERKSHIPS AND DRESSERSHIPS.

Clinical Clerkships and Dresserships, each lasting three months, in the Departments of Medicine, Surgery, and Gynæcology, and in the Special Departments of Diseases of the Eye, Throat, Ear, Genito-urinary system, Skin, Nervous system, and of Children, and in the Orthopædic Department, are at all times open to Candidates who furnish satisfactory evidence as to character and previous training. Applications for such appointments, the duties of which commence on the first day of January, April, July, and October, should reach the DEAN on or before the 1st December, March, June, and September, respectively.

Fee for three months' appointment, together with the right of admission to the Clinical Practice of the Hospital for three months, 20 Guineas.

NOTE.—Applications for admission to the above Classes should be addressed to the DEAN of the Medical School, Guy's Hospital, S.E., from whom further information as to the facilities for post-graduate work in these and other Departments of the School may be obtained.

The Chapel Choir.

A list is now posted every week in the Chapel lobby. All who are willing to sing in the choir on Sunday are requested kindly to write their names on the list as early as possible in the preceding week, in order to encourage others to do the same.

W. DENIS BROWNE.

Prize Examinations.

Competition for the undermentioned Prizes will take place on the following dates :—

JUNIOR PRIZES FOR GENERAL PROFICIENCY.

Wednesday, March 11th, 10–1, Elementary Anatomy; 10–1, Anatomy; 2–5, Physiology.

Tuesday, July 7th, 10–1, Histology; 2–5, Elementary Anatomy. Tuesday, December 8th, 10–1, Elementary Anatomy.

MICHAEL HARRIS PRIZE IN ANATOMY.

Wednesday, March 11th, 10–1. The date of the Practical Examination will be announced later.

THE WOOLDRIDGE MEMORIAL PRIZE FOR PHYSIOLOGY.

Wednesday, March 11th, 2–5. The date of the Practical Examination will be announced later.

BEANEY PRIZE IN PATHOLOGY.

Monday, May 4th, 10–1. The date of the Practical Examination will be announced later.

TREASURER'S MEDALS.

Tuesday, June 9th, 10–1, Surgery; 2–5, Medicine. Wednesday, June 10th, 10–1, Commentary on a Case in Medicine; 2–5, Commentary on a Case in Surgery. Thursday, June 11th, 10–1, Clinical Examination in Medicine. Friday, June 12th, 10–1, Clinical Examination in Surgery; 2–5, Operations.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY.

Thursday, March 12th, 10–1, Paper; 2–5, Practical. Friday, March 13th, *Viva Voce*.

The Examination for Open Scholarships in Arts and Science will be held on September 22nd, 23rd and 24th.

DENTAL PRIZES.

First Year's Prize in Dental Subjects.—Monday, March 16th, 2–5, Dental Surgery. Tuesday, March 17th, 10–1, Dental Metallurgy. Wednesday, March 18th, 2–5, Dental Anatomy.

1914 Prize.—Tuesday, July 7th, 2–4, Dental Mechanics. Thursday, July 16th, 10–1, Dental Metallurgy. Tuesday, December 8th, 2–4, Dental Mechanics.

Second Year's Prize in Dental Subjects.—Monday, March 16th, 2–5, Dental Surgery. Wednesday, March 18th, 2–5, Dental Anatomy. Friday, June 19th, 10–1, Dental Bacteriology. Friday, July 10th, 2–4, Dental Histology. Thursday, July 16th, 2–5, Operative Dental Surgery,

Second Year's Prize in General Subjects.—Tuesday, March 17th. 10–12, Surgery (including Surgical Pathology): 2–5, Anatomy. Wednesday, March 18th, 10–12, Physiology.

PRIZE FOR OPERATIVE DENTAL SURGERY.

The Examination for this Prize takes place in the Summer Session. The Regulations are given on page 49 of the Prospectus of the Dental School.

NEWLAND-PEDLEY GOLD MEDAL FOR PRACTICAL DENTISTRY.

The Examination for this Prize begins in the month of December. The Regulations are given on page 48 of the Prospectus of the Dental School.

SCHOLARSHIPS IN DENTAL MECHANICS.

Thursday, April 30th; Wednesday, September 30th.

No Candidate will be allowed to compete for any Prize unless he has given notice in writing to the Dean at least *fourteen clear days* before the commencement of the Examination.

University of London.

ALBERT KAHN TRAVELLING FELLOWSHIPS.

These Fellowships, of which two are awarded annually, are each of the value of £660.

As the recommendations of candidates for the Fellowships have to reach the Vice-Chancellor of the University

of London not later than the 28th inst., gentlemen desirous of competing should notify the Dean at an early date.

Particulars with regard to the Fellowships may be seen at the Medical School Office.

Guy's Hospital Medical School.

ENTRANCE SCHOLARSHIPS.

Five Entrance Scholarships in Arts and Science are offered for competition annually in September.

(A) SENIOR OR UNIVERSITY ENTRANCE SCHOLARSHIPS.

A first Scholarship of £75, and a second Scholarship of £35 open to candidates under 25 years of age, who have completed the curriculum for, or passed, the examinations in Anatomy and Physiology for a medical degree in any University of the British Empire, and have not entered as Students in any Metropolitan Medical School.*

Subjects.—Candidates for the above Scholarships will be examined in *any two* of the following subjects at their option, viz. :—Anatomy, Physiology, Pharmacology, General Pathology and Organic Chemistry.

(B) JUNIOR SCHOLARSHIPS IN ARTS AND SCIENCE.

1. A Junior Entrance Scholarship in Arts, value £100, open to candidates under 21 years of age.

Subjects.—English, Latin, Arithmetic and Algebra, Geometry, and either Greek, French, or German.

2. A Junior Entrance Scholarship in Science, value £120, open to candidates under 21 years of age.

Subjects.—Inorganic Chemistry, General Biology [Zoology, Botany], Experimental Physics, including General Properties of Solid, Liquid, and Gaseous Bodies, Acoustics, Heat, Magnetism, Electricity, and Optics.

3. A Junior Entrance Scholarship of £50, open to candidates under 21 years of age, to be awarded either in Arts or Science according to the discretion of the Examiners and the percentage of the marks obtained.

Further particulars, copies of Papers set at the last examination, and Forms of Application for admission to the examination may be obtained from—

THE DEAN, Guy's Hospital, S.E.

* University College and King's College, London, being now incorporated with the University of London, Students from those Institutions are eligible to compete for this Scholarship.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Abstract of Summary of Anæsthetics and Operations for the Year 1913.

THE number of cases in which general anæsthetics were administered was 6,801, among which were 187 intratracheal insufflations of ether. Spinal analgesia was employed on 34 occasions, and on 22 occasions spinal analgesia followed by a general anæsthetic. The total number of operations was 6,579 in Wards (Bright Ward excepted), Special Departments, Out-Patient Departments, and Surgeries. There was one case of death from anæsthetic, and one case of death during anæsthesia was also reported to the Coroner, particulars of both of which are furnished in the Appendix.

There have been 5,701 cases of general anæsthesia in the Dental Department, 5,360 under Nitrous Oxide Gas, 330 under Ethyl Chloride, and 11 under Gas and Oxygen.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the Table below showing how many operations are actually performed in these wards.

ANÆSTHETICS.

A.C.E.	452
Chloroform	282
Ether (including Gas and Ether)	1,237
C.E.	2,502
Gas	752
Other Anæsthetics, mixtures and sequences	1,386
Spinal Analgesia	34
Spinal Analgesia, followed by a general anæsthetic	22
Intravenous Ether	3
Intratracheal Insufflation of Ether	187
	6,857

ADMINISTRATION OF ANÆSTHETICS.

Staff Anæsthetists	1,510
Visiting Staff	196
Resident Surgical Officer	11
House Anæsthetists	2,997
Clinical Assistants	772
Other Qualified Men	1,371
	6,857

OPERATIONS.—TABULATED ACCORDING TO WARDS AND DEPARTMENTS.

Astley Cooper	321
Cornelius	325
Lazarus	313
Job	371
Naaman	319
Luke	299
Patience and Samaritan	356
Charity	309
Dorcas	394
Lydia	326

Martha	272
Eye Wards	645
Addison	35
Mary	46
Stephen	34
Esther	29
Queen Victoria	463
Clinical	62
Isolation	8
Out-Patients	1415
Front Surgery	196
Back Surgery	24
Light Department	16
Nurses' Sick Room	1
	6,579

Turning to the General Wards, it may be noted that the totals of operations are as follows:—

Surgeons	966
Assistant Surgeons	909
Specialists	39
Resident Surgical Officer	390
House-Surgeons and Assistant House-Surgeons	642
Surgeons' Dressers and Assistant Surgeons' Dressers	679
	3,625

the remaining 16 operations, bringing the total up to 3,641, were performed by other operators.

It should, of course, be remembered that all operations in Wards by Dressers and Resident Staff are performed under the supervision of the Resident Surgical Officer or of the Surgeon in Charge, and that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 480, of which 206 were performed by the Obstetric Surgeons, 114 by the Obstetric Assistant, 144 by the Obstetric Residents, and 11 by Dressers, while 5 operations were performed by other operators.

The operations upon Ophthalmic cases in the wards number 235, of which 56 were done by Ophthalmic Dressers, 13 by the Ophthalmic House-Surgeons, 19 by the Ophthalmic Assistants, 131 by the Ophthalmic Surgeons, and 16 by other operators.

There were 453 operations for Throat and Ear Diseases in the Wards: 328 by the Surgeons, 2 by the Resident Surgical Officer, 19 by the House-Surgeon, 22 by Clinical Assistants, 70 by Dressers, and 12 by other operators.

In the Orthopædic In-Patient Department 48 operations were performed: 36 by Surgeons, 1 by the Resident Surgical Officer, 1 by the Clinical Assistant, 4 by the House-Surgeon, and 6 by Dressers.

In the Genito-Urinary Department 77 ward operations were performed: 43 by the Surgeon, 9 by the Resident Surgical Officer, 9 by the Dressers, and 16 by other operators.

In the Front and Back Surgery 220 operations were performed: 1 by the Resident Surgical Officer, 43 by House-Surgeons or Out-Patient Officers, 4 by Clinical Assistants, and 172 by Dressers.

In the Special Out-Patient Departments 2 operations were performed upon Eye cases; 2 for Obstetric cases; 830 upon Throat and Ear cases, of which 9 were by the Surgeons, 56 by Clinical Assistants, and 765 by Dressers; 95 in the Orthopædic Department, 29 by the Surgeons, 14 by Clinical Assistants, 45 by Dressers, and the remainder by other operators; in the Genito-Urinary Department 16; in the Light Department 16; and in the Children's Department 1.

Convalescent Patients.

In accordance with annual custom the House Committee publishes for the information of the Medical, Surgical, and Nursing Staff, the following tables showing the total number of Patients sent during the past year to the various Convalescent Homes connected with the Hospital.

Wards.	Number of Patients. 1912.	1913.
Astley Cooper	37	46
Cornelius	27	55
Lazarus	60	42
Job	80	48
Naaman	32	49
Luke	46	69
Patience and Samaritan	42	25
Charity	59	59
Dorcas	58	61
Lydia	109	84
Martha	58	47
Eye Wards	15	20
Addison	59	63
Mary	40	43
Stephen	106	70
Esther	44	48
Queen Victoria	48	32
Clinical	72	80
Isolation	1	—
Surgery	—	1
Out-Patients	68	55
	1061	997

The subjoined list gives the distribution of the Patients amongst the various Homes:—

Ascot Priory	161
Barnet (Children's Home Hospital)	7
Bexhill and Little Common (M.C.I.)	42
Bognor (Merchant Taylors' Home)	16
Broadstairs (M.C.I.)	170
Cobham (Schiff Home of Recovery)	94
Rustington Convalescent Home	16
Shooters' Hill (Baroness d'Erlanger's Home)	25
Swanley (Parkwood)	286
Walton-on-Thames (M.C.I.)	70
Weybridge (Mrs. Vernon Carter)	14
" (Mrs. Heald)	4
Worthing (Miss Henry, closed April, 1913)	35
	940

SANATORIA.

(Beds allocated free of charge to the Hospital by the King's Fund; travelling and incidental expenses only paid by the Samaritan Fund.)

Didworthy (Devon and Cornwall Sanatorium)	6
Holt, Norfolk (Kelling Sanatorium)	13
	959

HOMES FOR THE DYING.

Friedenheim Hospital	1
St. Luke's House	1
	961

In addition to the above, 36 Patients have been sent to various places for convalescent treatment, principally in co-operation with the Charity Organization Society and the Invalid Children's Aid Association 36

997

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Musical Society.

DEAR SIR,—May we, through the medium of your columns, make an appeal on behalf of the Hospital Musical Society.

In Mr. Denis Browne, the Society has an excellent conductor, who spares neither pain nor trouble in trying to produce the best possible performances at our concerts, and it must be very disappointing to him to get such poor attendances at the rehearsals, resulting, on this account, in his efforts being practically wasted.

We, therefore, earnestly appeal to all members of the Hospital—both medical and dental—who are interested in music and possess voices, to join the chorus, and at the same time, may we impress upon those gentlemen who are already members of the chorus—and to a lesser extent the Nurses—the importance and necessity of regular attendances at the rehearsals.

The works that are at present being rehearsed are—numbers from the St. Matthew Passion (*Bach*)—which are to be performed in the Chapel on the Wednesday evening before Easter (April 5th), and

a. Blest Pair of Sirens ... *C. H. H. Parry.*
b. Five English Folk Songs } *R. Vaughan Williams.*
c. Five Mystical Songs }

which will be performed at the next concert held on Friday, May 1st.

The Practices, which have already commenced, are held on the following days in the Physiological Theatre: For the Passion Music—Full Rehearsals on Mondays at 8 p.m.; For the Concert Music—Sectional for Tenors and Basses, Mondays at 5 p.m.; Full Rehearsals, Fridays at 8 p.m.—Thanking you, Sir, for inserting this letter, Yours, etc.

H. Q. F. THOMPSON, }
Feb. 10, 1914. J. J. STERLING HILL, } *Hon. Secs.*

Papers by Guy's Men.

W. Hale White, M.D., F.R.C.P.: An Address on Glycosuria.—*The Lancet*, February 7th, 1914.

J. Dodds Price, M.R.C.S., L.R.C.P., and another: The uniform success of Segregation measures in eradicating Kala-azar from Assam tea gardens; its bearing on the probable mode of infection.—*British Medical Journal*, February 7th, 1914.

H. L. Duke, M.D., D.T.M. and H.: Wild Game as a Reservoir for Human Trypanosomes.—*British Medical Journal*, February 7th, 1914.

E. Graham Little, M.D., F.R.C.P.: A Hospital Unit in the University of Budapest.—*British Medical Journal*, January 31st, 1914.

R. Lawford Knaggs, M.C., F.R.C.S.: Retroperitoneal Rupture of the Duodenum.—*Clinical Journal*, February 4th, 1914.

R. A. Greeves, F.R.C.S.: Primary New Growths of the Lacrymal Gland.—*Royal London Ophthalmic Hospital Reports*, January, 1914.

Major A. J. Hull, F.R.C.S., R.A.M.C.: Recurrence of Inguinal Hernia.—*Journal of the Royal Army Medical Corps*, February, 1914.

Change of Address.

B. R. Parmiter, M.B., B.S., from Trinidad, B.W.I., to the Hospital for Consumption and Diseases of the Chest, Fulham Road, S.W.

F. Cook, M.B., B.S., to St. John's Hospital, Lewisham.

M. Fred. Hopson, Junr., L.D.S., to 65, Northbrook Street, Newbury, Berks.

L. Montgomery, L.D.S., to 108, Victoria Street, S.W.

N. Reader, M.B., B.S., from Westgate End House, Wakefield, to Guy's Hospital, S.E.

G. Dunderdale, M.D., B.S., to Lamu, British East Africa.

Gazette Special Pathologist.

H. L., MANCHESTER.—This specimen has the structure of an endothelioma of the palate. It is composed of alveolated masses of small cells in a stroma of fibrous and myxomatous tissue. It shows no evidence of malignancy.

V. J. H., WESTCLIFF-ON-SEA.—The centrifugalised deposit of this urine is moderate in amount, and contains many red blood corpuscles, a few leucocytes, extraneous matter, and large numbers of micro-organisms which may be of extraneous origin, especially if the specimen were stale. Tube casts, crystals, or further abnormalities are not detected.

PATHOLOGIST.

Rugby Football.

GUY'S v. CATFORD BRIDGE.

Except Broster, Guy's had a full side doing duty for this match at Catford on Saturday, January 31st. The turf was beautifully dry, but there was a strong wind that made passing at any distance rather fluky. The Catford pack put up a good fight for some time, but at length Danby broke away and looked certain to score; he chose, however, to punt over the full back's head against the wind, a very unwise thing to do, and a good chance was lost. Danby played exceedingly well from the line out, and his general display quite outbalanced the above error of judgment. Medlock could not quite fit in with Tom, but he got his three-quarters moving smartly several times, and Curle ran in on the left, to be followed almost immediately by Steyn on the other wing. Medlock's attempts at conversion were not quite successful.

After half time Danby got a try from a long run on Millett's part, which he ended with a punt, for the wind to carry the ball well on and Danby to dash away and kick the ball over the line for a try. Medlock neatly converted. Catford now put in quite a spell of attacking and gained two unconverted tries. This was the end of their efforts, for Guy's now completely assumed the upper hand, Steyn running in with two brilliant tries, one of which Medlock successfully negotiated from an awkward angle. Just before time Parry-Jones ran in with a perfect try, but it was not allowed. He was tackled from behind as he crossed the line. He fell, and his impetus appeared to partially carry him over the ball, but that he touched down with hand or forearm there could be no doubt at all. The referee was not up with the game, so could scarcely see what exactly happened. Final score: Guy's, 2 goals 3 tries (19 points); Catford, 2 tries (6 points). Team:—

GUY'S.—H. Millett (back); S. S. L. Steyn, N. Kendall, A. H. Harkness, C. L. Curle (three-quarters); C. H. Medlock, A. Tom (halves); C. S. Lane Roberts, O. Parry-Jones, M. B. M. Tweed, A. Liebson, C. H. Laver, G. E. Kidman, A. B. Danby, A. L. Anthony (forwards).

REMARKS.—Millett defended well, but again hung on the ball too long, especially right on his line. Steyn and Curle were excellent. Kendall was very uncertain in his handling, while Harkness did much useful work. A little quicker off the mark and fuller consideration of his wings' possibilities would be advantageous. Broster was much missed; Medlock will agree with the writer, I am sure. The forwards played well, Roberts, Parry-Jones, and Danby particularly. Just a little more "devil" would be welcome. The whole team are fast becoming a fine combination.

GUY'S v. ST. THOMAS'S.

1ST ROUND, INTER-HOSPITAL CUP COMPETITION.

The conditions at Richmond on Tuesday, February 3rd, when these teams met were perfect and a right good game was witnessed. It was a pity more Guy's men did not turn up. Those that were present are to be congratulated that their enthusiasm and encouragement amply made up for the absent ones. The first twenty minutes was a great struggle, Guy's attacking and Thomas's putting up a great defence. Millett came up with a nice run and sent on to Steyn, who was collared. Then Steyn passed nicely inwards to Roberts and Laver, the last named being floored about three yards out; but before many minutes more had gone by, Curle, fielding a miskick, dashed over at the corner. Guinness seemed to kick the ground instead of the ball in his attempt to goal. Several times Thomas's passed nicely, and Molina got off by himself neatly, but Millett was very safe. Our centres were not throwing the ball about enough. Broster was getting it away, but Guinness was not happy; Kendall and Harkness were boring too much. Broster and Guinness had not played together before, so there is ample excuse. A "get away" by Davies for St. Thomas's was the next feature. When almost clear he essayed a drop, going at full speed, and the ball sailed successfully over the bar. Once Tweed, who followed up very quickly, got Thomas's back in difficulties, and Danby doing the same just after almost gained a try, but Sparks came through quickly and held him.

Half-time arrived: Sparks was lame and Kidman had wrenched his knee badly. Honours were fairly easy. After another twenty minutes' ding dong, some good passing and a final dash sent Curle over with a try, which Millett goaled cleverly. We should have scored before this, but Guinness was so slow in swinging the ball away. A little later Curle punted high and followed up rapidly to gain the touch and another try, Millett again kicking a goal from a nasty position. Thomas's were now tired, Sloper, Davies, Proctor, Price, and Molina had done well. Their forwards, lighter than ours, were worn down. Broster put in one of his cleverest efforts and scored close in. Again afterwards, he opened out to Curle, who returned for Broster to run over by the post. These two tries Millett failed to add to, but from a much more difficult position he goaled a try that Steyn secured by very speedily following up an attempted drop at goal by Curle. Before the end Molina of Thomas's broke a bone in his leg and had to be carried off. Final score: Guy's, 3 goals 3 tries (24 points); Thomas's, 1 dropped goal (4 points). Team:

GUY'S.—H. Millett (back); S. S. L. Steyn, N. E. Kendall, A. H. Harkness, C. L. Curle (three-quarters); L. R. Broster, A. F. Guinness (halves); C. S. Lane Roberts, O. Parry-Jones, A. Liebson, A. B. Danby, C. H. Laver, M. B. Tweed, G. E. Kidman, E. F. Llarena (forwards).

REMARKS.—It was very bad luck not having Medlock's valuable assistance. It is the first Cup Tie he has ever missed. Millett was safety itself and his tackling splendid. Both wings played well. Curle's determination is good to see. Steyn did much useful work and very neatly. Harkness except for that tendency to get collared in possession was in happy vein. His punts for touch and sound defence were most useful. Kendall wants a little more experience. Broster has never done better. Guinness is a three-quarter; he did his best at out-half, and did it very willingly. Roberts was, without any disparagement to our foemen, the outstanding forward of the afternoon. Laver did well, too. Tweed and Danby, in the loose especially, played a good game. Liebson got us the ball with frequency. Llarena uses his

weight to the best advantage and every ounce of it, too. Parry-Jones played one of those hard and persistent games that one always gets from him. Kidman, damaged early, played on most pluckily, using that valuable weight of his all the time, though he must have suffered intensely. Train on thoroughly, in the next tie be more alert, more on your toes! Let the tackling be low and thorough, and of the forwards I would ask "more devil," yet "more abandon"; follow Roberts close up to the ball, and all together, not about nine yards behind the leader. By adopting vigorous tactics and by going all out, the team can face the future rounds with confidence.

GUY'S v. LONDON WELSH.

Just about an hour before this match was due to commence at Honor Oak Park on Saturday, February 7th, the high wind dropped very slightly and rain fell with dreadful persistence for the rest of the afternoon. The match was completely spoiled, both as a spectacle and as an enjoyable encounter. Foothold was a lottery, and the game naturally became a scramble in which the Welsh beat us. It is almost a waste of space to describe it. For several minutes we bombarded their line, and then till nearly half-time it was a ding dong struggle with one try, the result of forward play, falling to the visitors. Roberts had played grandly, Tom very pluckily, and Llarena had gone down to rush after rush. Guinness found touch with skill, but it was no day for passing runs or attack by open back play.

The second half saw us still further fall away, and two more unconverted tries brought the total of our defeat up to 3 tries (9 points) to nil. The final whistle came as a relief to all. Team:—

GUY'S.—H. Millett (back); G. B. Pritchard, A. F. Guinness, A. H. Harkness, C. L. Curle (three-quarters); A. Tom, C. H. Medlock (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. B. Danby, C. H. Laver, A. Liebson, E. F. Llarena, B. Laver (forwards).

REMARKS.—Some forwards played brilliantly, but some were very slack and very much offside. It is a great mistake not to get on side at once and join in the rushes from the back. The match with London will soon be here. The team are requested to keep themselves absolutely fit and in the pink of condition. Let all the forwards go out for all they are worth; the backs will, if they get plenty of the ball, do the rest. Both outside men should be liberally treated. Under Roberts's leadership and inspiring example the match may be looked forward to with confidence. Attack is the best defence, and with ordinary luck Thursday the night of the 19th should bring us a stage nearer to retaining the Cup in its present resting place for another twelve months.

Association Football.

GUY'S v. OLD CRANLEIGHANS.

Not having lost a match since last November, Guy's were very keen to win their last match before meeting London in the Inter-Hospital Cup, when they went down to Malden to play Old Cranleighans on Saturday, January 31st.

The wind was blowing very hard from the top end of the field, which rendered accurate passing very difficult. Coxon won the toss and, playing with the wind, Guy's at once started pressing, but shooting was very erratic owing to the high wind. In spite of the fact that the Old Cranleighans were only playing four forwards they managed to give Guy's defence a deal of trouble, although Welton, in goal, was not called on to save many times in the first half. Coxon eventually put Guy's ahead with a rather lucky long shot, and soon after ran through and scored again, which made them two up on the turn.

In the second half with the wind against them Guy's were very hard pressed, but they managed to keep Old Cranleighans out until C. H. Moon from a very questionable position ran through and scored. Guy's now pulled themselves together and attacked their opponents' goal continually, but could not get through. By an unfortunate piece of luck Lindsay, in attempting to clear a corner, kicked the ball into his own goal which put Old Cranleighans level. But Coxon replied soon after, so that the result was a win for Guy's by 3 goals to 2.

GUY'S.—F. E. Welton (goal); J. Kyle, E. S. Phillips (backs); L. Gill, D. A. Bevis (half-backs); J. A. Evans, —. Lloyd, A. C. M. Coxon, G. P. Lindsay, G. C. Williamson (forwards).

GUY'S v. CLAPHAM ROVERS.

On Saturday, February 7th, Guy's defeated Clapham Rovers at Honor Oak Park by 2 goals to nil. It rained incessantly through the greater part of the game, making the ground very difficult to turn on and the ball very slippery to control easily. Consequently the game lacked the dash and bustle of the cup-tie earlier in the week, and was, on the whole, rather disappointing. The game opened rather tamely—the slipperiness of the ball causing many mis-kicks,—and though some good passing by Guy's forwards soon carried the ball towards their opponents' goal, the shooting was far from good. During the greater part of the first half Guy's kept the play in the Rovers half, but they were unable to score until Phillips, having carried the ball a good way up the field, scored with a lengthy shot from some considerable distance off the goal. In the second half Clapham Rovers fell away considerably, and after various attempts at their goal Guy's eventually scored their second goal through Lloyd. Towards the end of the game, however, Clapham Rovers bucked up, and once or twice they very nearly got through—Welton making a very good save towards the close.

It is true that the conditions were hardly those that would call for good football, still Guy's must endeavour to keep up the form they showed against London if they want to do any good against St. Thomas's in the second round of the Inter-Hospital Cup.

GUY'S.—F. E. Welton (goal); J. Kyle, E. S. Phillips (backs); L. Gill, D. A. Bevis, —. Allen (half-backs); J. A. Evans, —. Lloyd, A. C. M. Coxon, H. V. Stebbings, G. C. Williamson (forwards).

Birth.

ZAMORA.—On February 9th, 1914, at 24, Overstrand Mansions, S.W., the wife of A. M. Zamora, of daughter.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Dental Society's Annual Dinner on Saturday, February 14th, was an unqualified success from every point of view. The speeches were on the whole very good and were distinctly above the level of those usually heard under such circumstances. Mr. Hopson especially gave us a delightful example of all that an after-dinner speech should be. A brief account of the dinner appears elsewhere in this issue.

Following last year's precedent, a Clinical Meeting was held in the Dental Department on the afternoon of the dinner. It was very largely attended by men who had come up to town for the evening's function—it is estimated that quite two hundred visitors put in an appearance during the course of the afternoon. Every phase of the School's activity was represented. There were some excellent examples of the work done by 1st and 2nd year Students in the Pupils' Laboratory, and of metallurgical appliances and methods by Mr. Pearce.

In the Conservation Room there was a very interesting collection of clinical cases and of specimens, whilst Mr. Doubleday demonstrated the use of local anæsthetics in conservative dental operations, and Messrs. Dowsett and Page the use of nitrous oxide for a similar purpose. Dr. Eyre had a very interesting exhibit showing bacteriological methods and specimens.

The new Radiographic Department was a centre of attraction for the visitors. Mr. Achner showed a collection of very excellent radiograms taken in the department, some of which we reproduce as an inset in this issue.

AT a meeting of the General Court of the Governors, on February 13th, Mr. C. H. Wells was appointed Clerk to the Hospital, which post has been vacant since the death of Mr. Henry Williams in December last. We desire most heartily to congratulate Mr. Wells on the striking recognition of his past services to the Hospital and School, shown by the authorities in appointing him to the responsible position of Clerk to the Governors. The readers of the GAZETTE are specially interested in the appointment, because Mr. Wells has been Financial Editor of the GAZETTE continuously since 1887. A brief review of some of Mr. Wells's past work in connection with Guy's will be found in another column.

At the same Court, Mr. R. W. Robbins was appointed Renter and Registrar, and Mr. W. J. Curry, Assistant Clerk to the Hospital. We congratulate both gentlemen on their promotions.

As no doubt most of our readers know, the names of all cases seen at Surgical Out-Patients who, whilst not immediately urgent, are recommended for admission and are not set aside for admission under any individual surgeon, are entered upon a list kept by the Resident Surgical Officer. They are then admitted in rotation into the surgical wards, a certain number of beds being set apart for the

reception of these patients in each ward. We do not know the exact number of beds admission into which is controlled by the R.S.O., but it is probably not more than a third of a total number of beds available on the surgical side. The cases so admitted are not, as we have said, those requiring immediate operation, which are, of course, admitted at once by the House-Surgeon for the week, but they form a fairly representative group of all the non-urgent surgical cases admitted to the hospital, and in all probability of the similar cases admitted to other general hospitals—at least to the other large hospitals in London.

The analysis of a return, recently made to the authorities showing the total number of cases admitted to the surgical wards through the R.S.O.'s list during the past sixteen months, affords us material on which to base an estimate, necessarily very rough, of the chief diseases and affections which the surgeon is nowadays called upon to treat by operative measures. The total number of cases so admitted during the sixteen months under review was 887. Of these, 662 were under the care of the full surgeons, and 225 under the assistant surgeons.

The diseases for which they were admitted may fall roughly into six chief groups, namely, herniæ, surgical tuberculosis, cancer, diseases of the breast, abdominal cases, and miscellaneous conditions. The cases of cancer necessarily include, of course, some of the cases grouped also under the headings of diseases of the breast and the abdomen. The abdominal cases do not include diseases of the uro-genital tract, nor, of course, herniæ.

As might be expected, the largest number fall into the great class of miscellaneous affections—in this group are 376, or 42 per cent. of the total. This number includes examples of almost every non-urgent surgical condition not included in the other groups, from an in-growing toe-nail to a fractured sesamoid bone. The next largest number falls under the heading of hernia, 271 cases, 30·5 per cent., being so classified. The next group is cancer, of which there are 102 cases, 11·4 per cent.; then come tuberculous cases, 89 in number, 10 per cent.; and abdominal cases 87, also 10 per cent.

It is a striking fact that herniæ should account for almost a third of the total number. If, as seems to be the generally accepted view, the majority of such cases are due primarily to some congenital defect, what is the factor which determines that this abnormality shall occur in such an immense number of men and women, whilst all other congenital mal-developments are, comparatively speaking, uncommon? The total number of cleft palates must form only a small fraction of the total number of herniæ. Perhaps, of course, a larger number of herniæ are being operated upon at present than was the case ten or twenty years ago and than will be available in the future. At present there is a general tendency to operate upon almost all cases of herniæ between the ages of one year and forty or fifty years. We may expect, then, as time goes on, and supposing always that the views of the surgeons do not materially alter, that fewer and fewer adults with herniæ will present themselves at out-patients. We are reminded here of a conversation we heard some little time ago at the Resident's table, between a prospective public health officer and a prospective surgeon. Each was extolling his own future work and disparaging his opponent's. Finally the public health man said: "Yes, but you know in a few years' time preventive medicine will have stamped out all the bacterial diseases, to say nothing of cancer, and then where will the surgeons be?" "Perhaps," replied the surgeon, "but even if the worst comes to the worst babies will still be born with patent vaginal processes!"

At first sight 10 per cent. seems an absurdly small proportion for abdominal cases, but it must be remembered that no urgent cases are included in this list, and also that in all probability if a comparison could be made with similar figures of twenty, or even ten years ago, the increase in the number of laparotomies would be very striking. In addition, a very large proportion of all surgical controversy rages around abdominal cases, and our attention is,

therefore, focussed excessively on the cases actually operated upon.

The Rugby Team were unfortunately not able to retain the Cup this year, but succumbed to our old rivals, the London Hospital, in the second round, on Thursday, February 19th. The game was a hard and strenuous one of the usual Cup-tie variety, but although our men did their best the London team were too good for them, especially in the three-quarter line. The final score was 11 points by London, to no score on our behalf. The result, although disappointing, is not without its compensations—our men have at any rate the satisfaction of having lost not through any ill-luck, or mischance, or for lack of sufficient energy or keenness in their game; and, after all, looking at the matter from a wider point of view, it is no doubt a pity that any one hospital should establish a monopoly in the Cup. A healthy rivalry serves to encourage and stimulate the spirit of all the schools, and prevents them from becoming slack, and losing interest in the competition. There is a poetic justice in our conquest by the London Hospital, who have been our chief rivals ever since they last held the Cup in 1908. We hope that their luck will not desert them, and that they will be successful in the subsequent ties. Their chief rivals will, one imagines, be St. Bartholomew's.

We have to congratulate Mr. R. W. Merriman, Demonstrator of Chemistry, on obtaining his D.Sc. London. We have also to chronicle with regret the retirement of Dr. Assheton from the post of Lecturer in Biology, which he has filled since 1901. Mr. T. J. Evans, M.A., has been appointed Lecturer in his stead.

The Special Course in Anatomy and Physiology for the Primary Examination for the F.R.C.S. will commence, as we announced last week, on Monday, March 2nd. The times of the classes have been arranged from 5 to 7 p.m. every evening, except Saturday, when they will be held from 10 to 12 a.m. These hours have been chosen in order to meet, as far as possible, the convenience of those men who are holding ward appointments and who cannot attend classes in the morning. The Anatomy classes will be held on Mondays, Wednesdays, and Saturdays, and the Physiology classes on Tuesday, Thursday, and Friday afternoons. Mr. Layton will meet the first class in Anatomy on Monday next, at 5 p.m., and Dr. Kennaway the Physiological class on Tuesday at the same hour.

Dental Radiography Department.

We publish in this issue as a supplement a selection of the very excellent radiograms which Mr. Achner exhibited at the Dental Clinical Gathering, on Saturday, February 14th. It is unnecessary for us to point out the merits of the photographs which attracted much interest from the visitors.

Appointments.

Civil.

Hildred B. Carlill, M.A., M.D., M.R.C.P., appointed Physician to Out-Patients at the City of London Hospital for Diseases of the Chest, Victoria Park, E.

Harry Lee, M.B., B.C. Cantab., F.R.C.S. Eng., Honorary Ophthalmic Surgeon to the Leeds Blind Institute.

Edward M. Mahon, M.R.C.S. Eng., L.R.C.P. Lond., has been appointed House-Surgeon to Mr. Gibbs at the Charing Cross Hospital, London.

F. W. Morton Palmer, M.A., M.D., B.C. Cantab., to be Honorary Medical Officer to the Teignmouth Hospital.

W. R. Ransford, L.D.S. Eng., has been appointed Dental Surgeon to the General Hospital, Rangoon, and Lecturer in Dental Surgery, Burma Government Medical School.

Change of Address.

F. R. Wallis, L.D.S., from Royal Infirmary, Bristol, to County Offices, Trowbridge, Wilts.

S. H. Browning, from 53, Welbeck Street, to 38, Harley Street, W.

Owen E. Williams, M.R.C.S., L.R.C.P., from Tre Morfa, Tal-y-Cafn, North Wales, to Hill Grove, Buckley, near Chester.

E. Royston Saul, to The Wolds, College Road, Eastbourne.

H. H. Davis, from The Ear and Throat Hospital, Edmund Street, Birmingham, to Broadhurst, Westbourne Crescent, Whitchurch, Cardiff.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

An Unusual Neurological Case for Diagnosis.

? Pseudo-Bulbar Paralysis.

ON December 29th, 1913, I was asked to see A. K., a man 55 years of age, and by employment a bricklayer. I found him in bed, where he had been for the preceding five days His wife, who proved a very intelligent woman, told me the following history of his complaint. Of his family or their ailments she knew nothing, as he was an only son, and both his parents had died when he was quite young. During the twenty-eight years they had been married her husband had never been ill.

As regards K.'s disposition, he had always shown a quiet and retiring nature, seldom speaking for any length of time. A single glass of beer rendered him more loquacious than was his wont, but on the whole he was an unusually sober man.

The present illness.—He first began to complain of headaches about a month ago, and his behaviour was at times very strange. He would lace up his boots, then look round for them, apparently having forgotten that he had just put them on. Similarly, when going to bed at night, he frequently forgot that he had taken off his boots, imagining that he was still wearing them. It was his wife's habit to prepare some lunch for K to take with him in the morning as he went to work. Occasionally, before starting, he would unpack the parcel containing this meal, with the remark, "This will not be needed to-day." At work he was heard to observe that mortar was unnecessary for bricklaying and cementing. Apparently, with the exception of the evidence afforded by the two preceding statements, there was exhibited no indication of delusions, systematised or unsystematised. He never spoke of anything that would lead one to suppose that he experienced hallucinations. For more than a fortnight his pipe has been discarded. Physically, he has become rapidly weaker, and just before taking to bed his legs "seemed unable to carry him."

For the past three days he has spoken to nobody, but lies passively, yet fully conscious, and passes his hand wearily over his brow. During these three days incontinence of both urine and fæces has occurred, and he has taken no food. When actually it is placed inside his mouth he seems quite unable to swallow it. Similarly, when fluids are introduced, they run out again at the corner.

The general condition.—He lies in bed with a resigned expression, taking little or no interest in his surroundings, yet quite conscious of all that occurs. Although speech is absent, he appears to understand all that is said to him, as he at once protruded his tongue and showed his teeth when asked to do so. He is able, more or less, to represent the sound of words, and says "Yes" fairly distinctly, although in a voice scarcely audible.

Owing to lack of the necessary facilities, a Wassermann test was not applied, but when a specific history was inquired for the answer was in the negative, indicated by a shake of the head. Further, a fact rather against the suggestion that the complaint was syphilitic in origin is, that not only did K. show none of the supplementary signs of specific disease, but he had had a family of five healthy children, with no deaths. Four of his sons are at present in the Navy. He shows a certain amount of muscular wasting, but scarcely in excess of what one would expect from the absence of sufficient nourishment.

The physical examination.—The temperature is normal, the pulse eighty to the minute, and the respirations twenty-four. His tongue is furred, the mouth somewhat moist, and the breath offensive. Retraction of the abdomen is seen, although it moves slightly with the respirations. The heart and lungs are quite normal, the radial artery not unduly thickened, and the urine contains neither sugar nor albumen.

The nervous system.—Eyes: The pupils are of equal size; the light and the accommodation reflexes are normal; there is no nystagmus. Cranial nerves: The ocular muscles show neither paresis nor weakness; the fifth nerve is intact. The seventh nerve: He is able to show his teeth well and to purse his lips; there is no labial tremor. His hearing is very good. The ninth and tenth nerves: There is complete inability to swallow, all attempts only resulting in movements of the lips. The absence of the faculty of speech was considered, for reasons which will appear later, to be due to laryngeal paralysis. The soft palate does not appear to be elevated upon his saying, "Ah." The twelfth nerve: The tongue is protruded normally without lateral deviation, it is neither tremulous nor is it atrophied.

Deep reflexes: The knee-jerks are present, equal and unexaggerated; the tendo-Achilles jerks are normal; there is a very slight continuous ankle clonus on both sides; the range of the movement is small, but the continuance is definite. In the upper extremities, the radial, ulnar, biceps, and triceps jerks are all slightly brisker on the right side than those on the left. There is, however, no sign of any paresis in this extremity; it seems no weaker than the left arm. He is able to grip equally well with either hand. There is no spasticity, the muscles of all the limbs being somewhat flabby.

Superficial reflexes: On investigating the plantar reflexes, the response is found to be flexor on both sides, the reaction being comparatively well marked. The abdominal and epigastric reflexes are both absent. There is no sensory disturbance apparent.

On December 31st, two days later, he sank into unconsciousness and died. When he was dead, I was told "that his big toes were pointing almost to his head." The conditions of general practice are alone responsible for the impossibility of obtaining a desired necropsy.

Commentary.—The earliest symptom noticed was the mental derangement, and since the condition is obviously a progressive disease of the nervous system, the change must have been of the nature of organic dementia. The commonest mental disease, associated with an organic cerebral change, is, perhaps, general paralysis of the insane But in the present case there seems very little justification for making this diagnosis. There was no Argyll-Robertson pupil, no tremor of the tongue or lips, no exaggeration, loss, nor any marked change in the condition of the patellar reflexes. Further, the mental condition was very different from that usually seen in general paralysis of the insane. The character was not greatly altered; excitement, delusions of wealth or grandeur, delirium, were all absent. The only symptoms of a delusional nature were his remark concerning his dinner, and his observation on the uselessness of mortar for cementing purposes. The incidents of his boots indicate amnesia, and that for very recent events. There is, then, little evidence to support a diagnosis of general paralysis of the insane, although, in the absence of post-mortem evidence, one cannot definitely exclude it.

The urine contained no abnormal constituents, nor were there any other signs indicative of uræmia; and there is little or nothing to suggest the presence of a cerebral tumour. Absence of speech and inability to swallow are two most prominent symptoms, and the fact that these two changes supervened together seems to point to a common origin. Also, there appeared to be paralysis of the soft palate: the motor part of the ninth nerve supplied only the middle constrictor of the pharynx, so that the tenth nerve was chiefly at fault. This would explain the presence of the paralysis of the palate, pharynx, and larynx. In other words, the condition of these parts could be accounted for by assuming the presence of a bulbar lesion. But the twelfth nerve has escaped, the movements of the tongue being perfectly normal. Further, in true bulbar paralysis, atrophy of this organ is a constant feature, and the face or lips are usually involved. The condition is not part of a progressive muscular atrophy, amyotrophic lateral sclerosis, nor has it followed diphtheria, typhoid, or influenza. We may say, therefore, that we are dealing with, not true bulbar paralysis, but pseudo-bulbar paralysis.

True, there is the possibility that the defect in speech may have been due to aphasia, and in the investigation of this symptom I was somewhat handicapped by the patient's inability to read or write. However, there was certainly no word-deafness as he understood all that was said to him. Aphasia usually, though of course not invariably, is accompanied by hemiplegia. We have seen that there was no paralysis of face or limbs present, and the only suggestion under this heading was the very slight exaggeration of the tendon reflexes of the right arm. Further, the subject was able to say "yes" fairly distinctly and produce other sounds resembling the words he wished to pronounce.

Finally, there were the other signs of vagal* involvement, so that one is justified in assuming the presence of laryngeal paralysis. If, therefore, we recognise pseudo-bulbar paralysis, how can one account for this change? Clearly it is not that variety occurring when there is a vascular lesion in each hemisphere. In this case the whole onset is too gradual for such a lesion; it has not occurred in two definite and separate attacks, and there is no double hemiplegia.

The most probable explanation is that bilateral cortical softening has occurred, chiefly in the lower region of the ascending frontal convolution. The slow progressive course up to a certain point, headache, and mental change suggest this view. To constitute what is termed pseudo-bulbar paralysis, two or more of the following organs must be paralysed: larynx, pharynx, palate, lips, and tongue.† In the case under discussion it occurs in the three first-named organs.

If bilateral cortical softening is the diagnosis, the absence of the superficial reflexes is accounted for, as they disappear almost invariably in organic cerebral diseases. It also explains in some measure the exaggeration of the right arm jerks, the slight ankle clonus, and the presence of incontinence. An extensor plantar reflex would scarcely be expected.

By the above consideration of facts, bilateral cortical softening with pseudo-bulbar paralysis is merely suggested as a probable diagnosis; it is far from my intention to dogmatise upon its validity.

My acknowledgments are due to Dr. French who very kindly read the notes of the case.

CECIL WORSTER-DROUGHT.

*In reality the motor nerve supply of the larynx is derived from that part of the nucleus ambiguus which also gives origin to the medullary or accessory portion of the eleventh cranial nerve. The fibres are, however, carried in the tenth.

†In a case of pseudo-bulbar paralysis reported from Dr. French's Out-Patients (G. H. G., March 18th, 1911), there was present paralysis of the lips, tongue, pharynx, and larynx, but no incontinence.

Papers by Guy's Men.

R. Davies-Colley, M.A., M.C., F.R.C.S.: A Lecture on Acute Necrosis.—*Clinical Journal*, February 25th, 1914.

R. A. Chisolm, M.A., D.M.: The Water Content of the Tissues in Experimental Nephritis.—*Journal of Pathology and Bacteriology*, January, 1914.

G. H. K. Macalister, M.A., M.D., B.C.: Direct Counting of Organisms with Dark Ground Illumination.—*Journal of Pathology and Bacteriology*, January, 1914.

G. Norman Meachen, M.D., B.S., M.R.C.P.: The Clinical Relationships of Lupus Erythematosus.—*Medical Press and Circular*, January 21st, 1914.

PAPERS RECEIVED.—The Hospital, Nursing Times, Gazette Medicale de Paris, Clinical Journal, Stethoscope.

The Dental Society.

THE Nineteenth Annual Dinner of the Society was held on Saturday, February 14th, at 7 p.m., in the Trocadero. Mr. F. N. Doubleday, the President, occupied the chair, and 256 members were present. The Treasurer of the Hospital, Viscount Goschen, Prof. Underwood, Mr. F. J. Colyer, and other distinguished representatives of the dental profession outside Guy's were among the guests of the evening.

The function was an unqualified success from beginning to end and reflects great credit on all who were concerned in its organisation. A striking feature of the evening was the keenness and enthusiasm of all the members, and no dinner could be anything but a success under the circumstances. The loyalty of this large gathering to their old Hospital was a striking testimony to the excellence of the School, and bids fair to establish a great tradition for the Dental School similar to that long established on the medical side.

After the usual loyal toasts had been proposed by the chairman, he called upon Mr. M. F. Hopson to propose "Guy's Hospital and Schools."

Mr. Hopson, who received an enthusiastic welcome from his audience, took as a text for the early part of his speech the triad "Faith, Hope, and Charity," and showed us how a similar rule of three held throughout the hospital. In the Medical School Office we meet Dr. Cameron, Mr. Croucher, and the janitor; in our preliminary work, Hancock, Baker, and Nash; in the wards, the Physicians, the Registrars, and Bell; in the administration of the Hospital, the Treasurer, the Superintendent, and the House-Committee; and especially in the work of the Dental Department, in treatment, we have fillings, crowns, and extractions; in extractions we use three anæsthetics, general, local, and magnetic, the difference between the two first mentioned and the third being sixpence; for dentures we may use springs, tragacanth, and gumption; the treatment of pyorrhœa is local, vaccine, and tonic; extraction is not treatment, but a *cure*.

Then, becoming serious, Mr. Hopson referred to the debt we owe to the School and Hospital. Our horizons are widened, our views made broader and more charitable. We lay there the foundations of any future professional success. We form there those friendships many of which will last throughout our lives. We are imbued with that spirit which is so characteristic of Guy's, where, as nowhere else, Governors, Staff, and Students all work together in harmony for the common good of the Hospital and Schools. And in return we develop an affection for the old place which makes us loath to leave and eager to return and lay any sprigs of laurel we have gathered in all affection on the altar of Guy's.

Viscount Goschen, who returned thanks on behalf of the Hospital, referred to the influence of the Dental Society in the life of the Hospital and the distinction it conferred on Guy's. He emphasised the fact that nowadays more and more expert knowledge was expected from professional men, and that this demand was leading to an increase of specialism in every branch of professional work. This was, perhaps, not altogether an evil, but it was essential that the specialist should not become too narrow and, above all, should not forget the centre from which he was sent out nor the traditions and the spirit which he learned there.

Dr. Cameron, the Dean, who replied on behalf of the Medical and Dental Schools, said that it is always satisfactory to speak of that which is thriving and flourishing. The Dental School has definitely entered upon a career of prosperity. He went on to refer to the great changes in the School in recent years—the rebuilding and extension of the Conservation Room and the Laboratories, the establishment of a Radiographic Department, the improvement in administration consequent upon the appointment of Mr. F. B. Bull as Resident Dental Officer. He referred to the astonishing entry of new men in October last and to the fact that very many of the new men were brought by old and even by present Guy's men. At the same time, like all successful institutions, the Dental School were not yet satisfied. They desire to forward knowledge of dentistry as a whole. Some research work is already being done, and it is satisfactory to know that an anonymous donor has provided Dr. Lowry with money to carry on work in metallurgy, but more is needed for other branches of dentistry. Men already in practice can assist materially in this direction by impressing upon their patients the need for research in dental surgery.

The toast of the Dental Society was proposed by Mr. Wynne Rouw, who emphasised the value of attendance at meetings of the Society, especially in teaching men to express their views. He foreshadowed a change in the arrangements for the Annual Dinner. The change would be in the direction of less speeches and separate tables for men of different years as is done at the Biennial Dinner.

Mr. Doubleday, who replied, reported that a record number had attended the dinner, no less than 256 sitting down to table that evening. He gave a brief résumé of the work of the Society and made an appeal for further support for the Dental Chair Fund for the Conservation Room.

Mr. Malleson proposed "The Visitors," and Mr. F. J. Colyer replied.

Between the speeches we were delightfully entertained by Mr. F. Sterndale Bennett, Mr. F. W. Sheldon, Mr. R. H. Rix, Mr. Stirling Hill, and Messrs. G. H. Howe, F. W. Stiven, and C. H. Williams.

On Friday, February 13th, the Dental Society met under the chairmanship of their President, Mr. Doubleday. After the usual formalities, and the showing of two Casual Communications by Mr. Clewer, the President asked Mr. Barnes to read his paper on the subject of the Present Day Diet and Its Dental Evils. A considerable amount of discussion ensued. Mr. Fry, speaking not from personal experience we hope, maintained that alcohol had a beneficial action on the teeth. Messrs. Viljoen and Van Schalkwijk talked about the teeth of South African natives, and others who spoke were Messrs. Rix, Hollands, Clewer, Duggan, Millett, and Deverall. The opinion of the meeting seemed strongly in favour of a radical modification of our diet.

DENTAL CORRESPONDENT.

The Debating Society.

On Saturday, February 21st, a debate was held in the College, the subject of which was "That in the opinion of this House modern fashions are decadent." It would need an expert parliamentary essayist to make a truthful report of the proceedings at all readable.

Only thirty odd members were present, and of these only a few took part in the discussion; and but for the inexhaustible humour of the Chairman and Dr. Mann, the House would have adjourned long before the usual hour.

A few individual speeches were undoubtedly good, but the general level of the debate was distinctly mediocre, while men sat and looked at each other for quite long intervals before anyone realised the humour of the situation.

Mr. Sampson, who opened the discussion, was very fluent, but his arguments were somewhat primitive; Mr. Maxwell a little too deliberate; Mr. Martin wholly delightful, but far too short. Mr. Blake has a charming way of saying nothing with a good deal of skill, while the old guard was represented by Mr. Ryle, who can always be relied upon to add substance to the debate. For the rest there is little to say.

One is reminded of a clever speaker's reminiscences. "The first time I went to a public debate," he said, "I remained unavoidably silent. The second time I got up and immediately sat down again. The next time I said, 'Sir, I entirely agree with the former speaker.' On the next occasion I could only find words in which to express my disagreement with that speaker, but on all subsequent occasions my tongue ran away with me."

We commend the above story to all members interested in the welfare of the Society.

A hearty vote of thanks was proposed to Mr. Thompson for his kindness in taking the chair. The committee would like to take this opportunity, at the end of the Society's year, of cordially thanking everyone who has helped to put new life into the proceedings of the Society, and to express the hope that during the next session it will be even better supported than in the past.

From the Tropics and the East.

MANY of our readers will be glad to hear of two former Residents who have gone to the East: of Geoffrey Dunderdale, R.M.O. in Bright from 1911 to 1913, and Kenelm Digby, H.S. to Mr. Symonds, and Surgical Registrar. The former has joined the Colonial Service in British East Africa with Nairobi as a centre, while Digby has been appointed Professor of Anatomy in the University of Hong Kong.

In his sketch of the country, Dunderdale speaks of the heat of Mombasa—120° in the shade—as a trifle, and welcomes the green of the trees, the blue water and sky as a set-off against the troubles of the customs. Here he met A. D. Williams, some time one of Mr. Dunn's dressers, who gave a helping hand. He was, on arriving at Nairobi, put in charge of the Native Hospital, the troops, and the jail, and at once became busy with medical and surgical work and some midwifery.

"My predecessor," he says, "had been attacked by cerebro-spinal meningitis, or as abbreviated here, C.S.M. He had just recovered when I arrived, and was going on leave. This disease has simply decimated the natives here in the last few months, and a few whites have had it. My predecessor, Dr. Shircose, himself found out that Soamin had a curative effect, and he was ultimately cured by his own discovery, but I must say the whole thing was somewhat of a revelation to me. I always regarded cerebro-spinal meningitis as a disease chiefly of young children, nearly always fatal, with only symptomatic treatment. Here it is apparently commonest among young adults, and can, in many cases, be cured. Antimeningococcic serum has been of no use, but soamin has been very successful as the results obtained by Dr. Shircose at the Native Hospital and Dr. Gilks at the European Hospital will show. There are still cases, but I do not see much of them, as they all have to be notified and sent to Isolation Camp. I do a good many autopsies on cases found dead—alas, no guineas for a B.I.D. out here—and the pathological condition is generally very definite.

"I cannot imagine a more varied range of work than one gets here. I see white officials, white settlers (private patients), Indians, and Natives of all kinds. I do medicine, surgery, midwifery, public health and sanitation, anæsthetics, and last, but by no means least, any amount of office work. My one regret is that I have no time to profit by all the clinical material, and a great deal of surgery is denied me because the native patient will generally run away rather than be cut. Among my cases have been small-pox, chicken-pox, mumps, any amount of pneumonia, and fractures and injuries of all sorts in natives.

"Only yesterday I did a p.-m. on a small boy of 12 with the most wonderful adherent pericardium, half an inch thick in its thinnest place. Another man, who died recently of ankylostomiasis primarily, had the biggest abscess I ever saw in his chest. I could not make out whether it began in the lung proper, or as an empyema, but what I found was a small piece of compressed lung which might have passed for the upper lobe, perched on top of a huge abscess filling all the left side of the chest. I estimated that there must have been four pints of pus altogether. Many natives are very hard to diagnose as history and symptoms are so very vague.

"Yesterday I attempted a plastic operation for contracted socket to enable a man to wear a glass eye, but there were such extensive fibrous bands that I doubt the success of the operation, and now I am going to do a radical cure of inguinal hernia on a native, and hope he will send all the other herniæ along, too. So, you see, I am getting some surgery, as beyond these I have done two amputations and opened a knee-joint, but most of the Europeans go to the Medical Officer at the European Hospital. I sent him a very good case of twisted ovarian cyst following labour, and helped him to remove the cyst a few days later."

Nairobi he finds dusty and insanitary, living expensive, and prefers the coast in spite of the greater heat. Like all such services a man must be prepared to go where he is sent, and in the early part of his service may find little scope for any special surgical training, however highly qualified he may be.

"All home news is very welcome, and the GUY'S GAZETTE is a very cheering arrival. I shall think of the old place this Christmas and wish myself back, I know, and when I come back and want tinkering up I shall certainly claim a bed in Bright. I am glad I did not leave the hospital without experiencing the delights of being warded. My two short spells in John were thoroughly enjoyable, in spite of the drastic treatment to which I was subjected by one of my clinicals."

He would like to see a certain number of Medical Officers set apart for research. He finds it difficult enough to get round his wards, and is obliged to leave all ordinary treatment to Indian assistants.

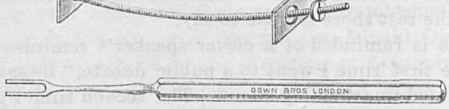
Kenelm Digby sends a picture of the University showing a view over the harbour. The building is large and even imposing and stands well up the hillside. "I have," he says, "a large and entirely separate building all to myself.

"This includes a well-lighted and airy dissecting-room to accommodate up to 200 students. I have a research laboratory and an office of my own. There is also a prosector's laboratory, a fairly spacious museum, a good lecture theatre, a students' sitting-room, and several storerooms; also an embalming-room and a machinery-room, for we have an ammonia engine and cold storage, so that we shall have none of that drying-up of the parts overnight. I hope in a year to have an epidiascope in the theatre, and there is no shortage of bodies.

"The students are Chinese, Malays, Indians, 'mixeds,' and a few Europeans. They are all excellent men to teach and quite keen; so that as far as the teaching work is concerned, you see I have nearly all anyone could want, and the scientific work is delightful."

Appliance for the Treatment of Fractured Patella.

THE patella clamp illustrated below, and made for me by Messrs. Down Bros., consists of a thin silver plate to which are attached two threaded silver wires. The fragments of a broken patella are drilled in the long axis of the bone, care being taken to make the drill holes the required distance apart. The wires are sufficiently rigid to be easily inserted, but may be readily bent to any required angle. Over the projecting ends of the wires a second silver plate is passed and the bevelled nuts, lightly clamped for the purpose in a pair of artery forceps, are screwed up into apposition with the plate. The redundant portions of wire are cut away and the nuts thoroughly screwed home by means of the special screw-driver provided, the first plate being at the same time hammered into position. This manœuvre causes more wire to project beyond the nuts, all of which is cut away with the exception of a small piece left for riveting. The riveting is important to prevent the nuts from working loose. Simultaneously with the riveting the second plate is hammered into shape.



The advantages of this method of treatment are (1) The *screwing up* of the fragments together, whereby the bones are brought into close contact. (2) The unlikelihood of the retaining apparatus pulling its way out, as is liable to happen when the ordinary method of wiring is employed. (3) The absence of ugly projections from the surface of the patella with subsequent irritation of the overlying skin. (4) The absence of screws which, owing to the softness of the patella may fail to grip at all or subsequently work loose when strain is placed upon them. (5) Immediate security of the fragments (as opposed to the use of catgut), enabling early passive movements to be carried out.

N. READER, M.B., B.S.

Sight Testing.

CLINICAL LECTURE BY MR. A. W. ORMOND.

GENTLEMEN,—In starting your work in the Ophthalmic Department you will be struck at once by the large number of patients who need spectacles, and it is absolutely imperative if you are to attempt any useful ophthalmic work that you master all the methods necessary for finding out the refraction of cases and what glasses, if any, will help the patient.

I intend to-day to draw your attention to some facts the consideration of which will, I hope, make this work easier for you, but I wish to avoid as far as possible all complicated details, and to show you how you may correctly diagnose and often treat your patients with a *minimum* of special knowledge if only you pay attention to the minutiæ of the various steps in the examination.

The facts recorded on the out-patient letter are few, but all are essential. If the letter is properly completed it should contain the name, age, and occupation of the patient; the age is most important as presbyopia, one of the conditions for which glasses are required, does not need treatment before the age of 43, and so in younger patients you may dismiss that consideration. Also there is a great difference in the *method* of dealing with children and old people, the "accommodation" or focussing power which is effective in children is almost a negligible quantity after 50; elderly people can tell you accurately facts regarding their visual troubles and the reason why they seek your aid, whereas children are often sent by their parents or the school authorities.

The *type* of occupation is also important; a clerk, seamstress, lacemaker, or typist use their eyes for "close" work, whereas navvies, porters, labourers, etc., make no exacting call upon their accommodation, and trifling errors which would worry the former group and need treatment would not be noticed by the latter at all.

First of all, then, notice the age of your patient, his occupation, and listen to his history. Often the patient states laconically, "want glasses," leaving it to you to elucidate the previous history of the symptoms which have led them to attend at the hospital, probably one of the following: aching or watering of the eyes, tiredness, frontal or occipital headaches, heaviness or inflammation of the lids, giddiness, inability to see to read, or to see in the distance, refusal by the Post Office, Army, or Navy. If you attempt to ascertain how long these symptoms have troubled them you will probably be baffled by such statements as, "Oh, a long time," "since before baby was born," or simply, "don't know," which is no doubt the truth, as the onset is so insidious that no definite period can be fixed. When a patient tells you that the sight was noticed to be defective on a certain day at a fixed time, the case is probably not one in which an error of refraction is the cause, although even here we find an exception, as lads will often tell you that they have come because they cannot see out of one eye, and if you ask how long they have noticed it, they will tell you the exact day; which is, on inquiry, the day they were tested by the postal or other authorities.

Having recorded briefly the main symptoms, you place your patient in front of a well-lighted set of Snellen's test types and at a distance of 20 feet; now cover up the left eye and make the patient read with his right eye alone the letters starting at the largest and going on to the smaller ones and note three things: How many letters are read correctly, how many incorrectly, and how quickly or easily they are read. Then uncover the left eye and, covering the right, test the left in the same way. Having done that and recorded the result, give the patient the "Jaeger" reading types and see what is the smallest print that he can read, at what distance it is held from the face, and how easily it is made out. This is a very simple matter and can be undertaken by any student without previous training, and yet with the facts thus obtained 50 per cent. of the cases can be correctly diagnosed.

We have by this means tested the patient's visual acuity, but it is necessary here to explain what Snellen's distance test types represent.

It is assumed by physiologists that the smallest object that can be perceived must subtend an angle of one minute on the retina. All Snellen's types are composed of lines which are one-fifth of the size of the whole letter, and each letter subtends an angle of five minutes when seen at certain varying distances. It is clear, therefore, that each stroke of each letter subtends an angle of one minute at each of the varying distances.

Now take the largest letter at the top of the set; this letter when seen at a distance of 60 metres subtends an angle of five minutes,

and each stroke or part of the letter subtends an angle of one minute. Hence, 6/60 means that at a distance of 6 metres the patient sees a letter which he should see at a distance of 60 metres, that is to say, the visual acuity is one-tenth of the normal, and the same thing applies to the rest, 6/36, 6/24, 6/18, 6/12, etc., viz., that each letter, at the varying distances of 36, 24, 18, 12, etc., metres subtends an angle of five minutes. For example, 6/12 means that the patient sees at 6 metres the letters which should be seen at 12 metres by the normally sighted ; thus, the visual acuity stands at half the normal. Snellen's types, then, are arranged for determining the visual acuity at the macular and are calculated on a definite scale which assumes that the smallest distinct object which can be seen on the retina must subtend an angle of one minute at the nodal point of the eye, that is, an angle equal to 1/5400 of a right angle.

The reading test types for close work are not calculated on any scale, but are merely specimens of printers' types collected many years ago by Jaeger of Vienna.

We have now to consider the possible conditions of the eyes apart from actual disease which may be giving rise to the symptoms. They are simple myopia, myopic astigmatism, simple hypermetropia, hypermetropic astigmatism, mixed astigmatism, and presbyopia. Myopia implies short-sight, inability to see clearly in the distance, but objects close at hand may be seen easily. Hypermetropia is long-sight. The eyes are focussed for distant objects and in order to see anything clearly focussing or accommodation must take place. Astigmatism, a very impressive word, implies that the cornea is not a section of a sphere, but is shaped more like a section of an egg than a ball. The curvature of one meridian being a segment of a smaller circle than the other, as in an egg, the long axis has a curve which is a segment of a larger circle than the vertical or short axis; so in the eye the cornea may be compressed laterally or vertically and the image of any object seen by that eye is received by the retina in a blurred and indistinct manner.

Presbyopia is not really an error of refraction at all; it is the physiological result of a life-long process by which the lens becomes harder and less able to assume a convex shape; thus, the near point of distinct vision is constantly receding from the eyes. When you were aged 10 you could read small print much closer to your face than you can now at 20; in another ten years the distance will still further increase, and at 50, if you are normally sighted, you will find that you are unable to read Bradshaw's time-table even at arm's length, but you can aid the lens by means of convex glasses in the form of spectacles.

Now let us take a few cases to illustrate the foregoing points. Suppose neither eye sees the top letter, or only just sees it, but reads the smallest reading print quite easily at a shorter distance from the face than 12 inches=myopia. If the small letters are read by each eye separately and small reading print cannot be seen at any distance, the case is one of hypermetropia, if the patient is under 45, or a case of presbyopia if the patient is over 45.

If more letters are read than are correctly seen, astigmatism is probably present, certain parts of the letter appearing to the eye to be more distinct than another; for instance, an F will possibly be called P, or C an O, or a V a Y.

If a patient under 40 reads the last line but one the case is probably one of hypermetropic astigmatism. If all the letters are read correctly myopia can be excluded. If the first three lines are incorrectly read myopic astigmatism is probable, whilst if the patient can read the last two lines, but reads incorrectly, hypermetropic astigmatism is more likely.

Having, then, ascertained the visual acuity of each eye separately, and also the reading capacity of the unaided eye, we can do one of two things: either attempt to bring the vision up to 6/6 with glasses, or if the patient can already see 6/6 without a glass, see if 6/6 can still be seen with a convex glass or a convex cylinder. I say convex because we have already stated that when a patient can see 6/6 he cannot be myopic; therefore, he must be either hypermetropic or astigmatic.

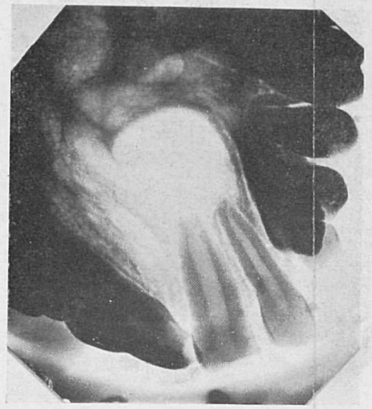
The alternative thing that we can do is to amplify and corroborate our surmise as to the diagnosis by means of retinoscopy before we attempt to employ the test lenses.

To carry out a retinoscopic examination thoroughly it is necessary to have the pupils dilated and the accommodation fixed by a mydriatic, but, on the other hand, much useful information can be obtained by a rough examination of a patient in a darkened room without a mydriatic.

Extinguish all lights except one, which should be placed behind the patient's head. Make the patient look straight in front of him and at a

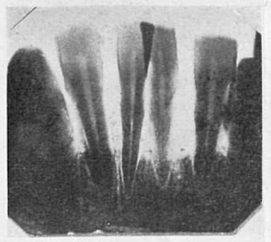
1. Small cyst caused by buried root of first premolar.

2. Cyst caused by bristle which was probably pushed through the apical foramen of the root canal.



3. Cyst caused through injury of central incisor.

4. Necrosis of bone originating from badly crowned lateral.

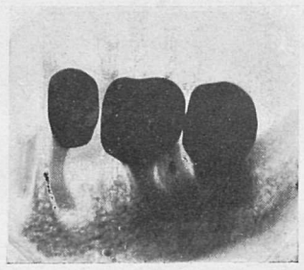


5.

6.

5 and 6. Rarefaction of bone due to Pyorrhœa.

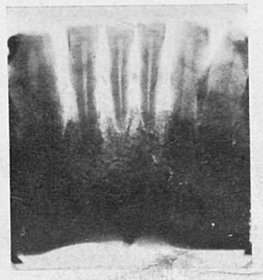
7. Empyema of antrum caused by abscess of first molar.



8. Abscessed root of premolars and extensive absorption of alveolus due to badly fitting crowns.

9. Palatal abscess due to lateral

10. Cancellous bone and lamina dura well seen.



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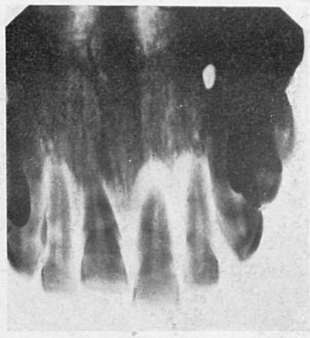
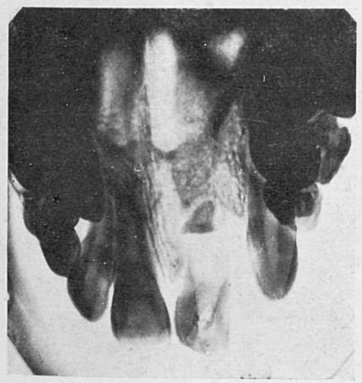


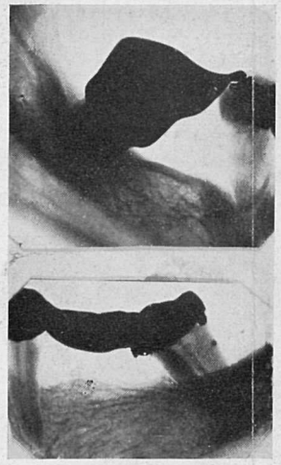
12.

11 and 12. Rarefaction of bone due to Pyorrhœa.

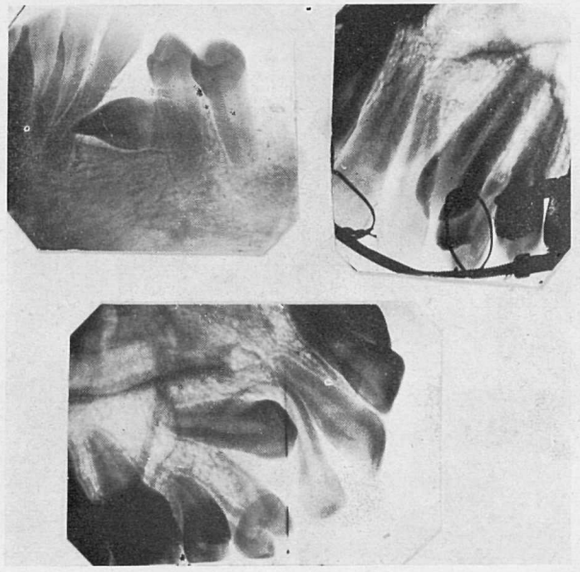


13. Absorbed root of fractured central incisor.

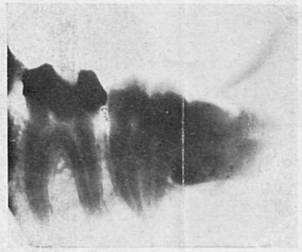
14. Premolar erupting between canine and lateral.



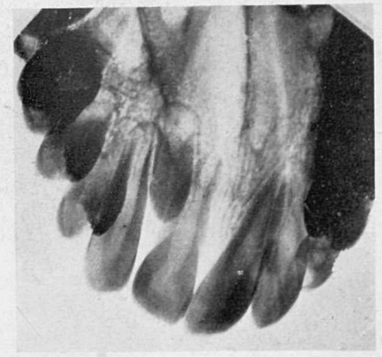
15. Septic bridges and extensive rarefaction of bone.



16. Unerupted canines pressing on laterals.



17. Wisdom tooth erupting at right angle to second molar.



18. Lateral in the development stage showing crypt.

A few Film Skiagraphs selected from the collection exhibited at the Clinical Afternoon in the Dental X-ray Department.

far distant point. This will enable the pupil to dilate and the accommodation to relax. Now, standing at a metre in front of the patient, throw the light from your ophthalmoscope mirror into the eye; you will, if you look through the hole in the centre of your mirror see a bright red reflection, circular in shape, and varying in size with the size of the pupil. Hold the ophthalmoscope steadily, and still looking through the hole of the mirror rotate the instrument on its long axis in such a way that as the mirror revolves the light on the pupil is transferred to the parts around the eye; the pupil now appears as a jet black circle, and you are to observe that the transference of the light away from the eye may be accompanied by a shadow which moves either with or against the movement of the mirror. If it moves "with," the patient is myopic, if "against," he is hypermetropic. If the shadow moves with the mirror in one meridian, say the vertical, and against, in the horizontal, then astigmatism is present.

Having thus verified our surmise as to the refraction of the case, and also by this casual examination ascertained that the media of the eyes are healthy and clear, we can try to improve the patient's vision by treating with lenses.

Mere sight testing is almost certain to fail in children and young adults who still have a vigorous power of accommodation. In cases of hypermetropic, myopic, and mixed astigmatism also, difficulty is experienced, the reason being that it is hard to apportion the relative amount of astigmatism to the hypermetropia or myopia present. For instance, a patient can seldom be sure if he sees any difference between a +·25 sph. combined with a +·75 cyl. and a +·5 with a ·5 cyl. or a +·75 sph. and a +·25 cyl. In each of these combinations you have one meridian fully corrected, and you only alter the meridian at right angles by ·25 diopters, which is seldom sufficient to attract the attention of any but a very discerning patient with a keen visual acuity.

It is important to remember that if a patient sees as well in the distance with a convex lens as without he is hypermetropic. The hypermetrope can cover up his error of refraction, that is, he can adjust his focus to his needs, but remember that all focussing means muscular action, hence the hypermetrope does not usually complain of his sight; on the contrary, it is an everyday occurrence for the surgeon to be told, "Oh, my sight is perfect, there is nothing wrong with that." What the hypermetrope does complain of, are symptoms which can be attributed to overaction of a muscle (the ciliary muscle), such as fatigue, headache, pain in the eyes, etc. These symptoms are all increased when the long sight is accompanied by astigmatism.

Myopia, on the other hand, cannot be compensated for by any effort of the patient; nothing he can do improves to any marked degree his distant vision, except that occasionally a myope will see a little better by screwing up the eye-lid and so obtaining a "stop" effect and reducing the circles of diffusion. On the other hand, he is focussed for objects lying close to him, and, therefore, he can read for hours at a time without experiencing any sense of fatigue; he rarely complains of tiredness of the eyes or headache, but is generally conscious that he cannot see as far in the distance as other people.

Astigmatics are always "out of focus," and have no position where they can see correctly and without effort.

The ideal state of the ocular refraction is when the eye at rest is focussed for distance, so that every object seen at a distance forms a sharp image on the retina and for the focussing of "near" objects the accommodation is used.

This condition does not always exist. Either the eye is so constructed that parallel rays only meet behind the retina (hypermetropia), and then the accommodation must be used to increase the refractive power of the dioptric media (cornea, lens vitreous) for distance, as well as for near objects; or, on the other hand, we may have too great a refractive power, parallel rays of light coming to a focus in front of the retina, so that only divergent rays of light, *i.e.*, rays of light coming from "near" objects are brought to a focus on the retina, and the parallel rays need a concave lens to enable them to be focussed.

The terms "near" and "far" are used as meaning nearer than 20 feet or further than 20 feet away.

In testing each eye separately take care that the eye not under examination is really covered up, as in some cases of squint the sight in one or other eye is very defective and the patient will often unconsciously, by a movement of his head render any partial covering of his eye, as, for instance, an opaque disc in the spectacle frames, null and void; to obviate this always

use a piece of paper or covering sufficiently large and close to the eye to prevent any such possibility.

Let us take a case in which the patient sees the last line or last line but one, and is 30 years old. Take a +·25 spherical lens, hold it in front of the eye; if he can see as well with it as without, he is hypermetropic. Several other reasons support this diagnosis:—

1. He complains of difficulty in close work.
2. He reads the distant types well.
3. By retinoscopy the shadows go "against" when seen by the ophthalmoscopic mirror.
4. He sees as well with a +·25 sph. lens as without.

Now take another case. The patient cannot see the top letters or can only just see the top one. Try the Jaeger types and you find that he reads the smallest print easily, but at a distance of 6 to 8 inches from his eyes; he is, therefore, myopic. Note that the pupils are rather larger than usual because the patient, being unaccustomed to using his accommodation, the associated movement of convergence, contraction of the pupil, and accommodation does not take place to so great an extent as normally, and the pupil is, on an average, rather larger in myopia than in hypermetropia. Also as a further proof his vision is impaired by a +·25 sph.

A myope who can only just see the top letter has usually about 4 diopters of myopia, and if a concave lens of 4 diopters is put in front of his eyes a marked improvement in his visual acuity will take place at once.

Another detail of technique is sometimes very useful in sight testing. If we suspect that the patient has some astigmatism, and we wish to find out if this is so, and in what meridian the axis of the cylinder should go, we first of all improve the visual acuity with spherical lenses as much as possible, then, taking two cylinders of equal strength and the same curvature, that is, both concave or both convex, we hold one with its axis vertical and the other with its axis horizontal, the one will increase the astigmatism and the other will diminish it. With the one the patient's vision is improved and with the other made worse. So to the question, "Do you see better with this glass or with that?" the patient's answer is generally of great assistance in determining the presence of astigmatism and its direction. If the answer given by the patient is doubtful, turn the axis of the cylinders obliquely and try the same question with the axes down and in and down and out. If the patient has no astigmatism the cylinder will render vision worse no matter in what direction it is lodged. The most useful occasion for this test, because of its frequent application, is in cases where the patient reads 6/6 with each eye separately, but complains of headache and tiredness of the eyes. Hypermetropia is possibly present, but a small amount of hypermetropia not being, as a rule, sufficient to cause headache and asthenopic symptoms, astigmatism is probably there also. Take two convex cylinders of ·5, and, holding one vertical and one horizontal, ask the patient if he can see any difference with the one or the other. If, as is likely, he pronounces that one is better than the other, then you know that astigmatism is present, and you also know its direction. It only remains to ascertain its strength, and this you do by holding higher or lower cylinders in front of the eye with the axis in the direction in which the patient sees best, and his answers to your query as to which he sees best will decide the strength.

If a patient is over 40 he or she is in the presbyopic age, and a special calculation must be made in order to settle what glasses will be needed for reading, as after 45 the same glass will not be accepted for distance as for reading. The rule generally given is that an addition of one diopter is made to the distance glasses for every five years after 40. This rule is like many another rule, incorrect when taken literally, but is sufficiently useful and simple to remember, and to make it the basis of our calculation. According to this, it would work out that a patient of 45 requires +1 D. sph. for reading added to the correct distance glasses; that is to say, if the patient is hypermetropic, say one diopter, he would require +2 D. sph. diopters for reading. When he should become 50 years old he would be given +3 D. sph., that is, +1 sph. for his hypermetropia and +2 sph. for his age.

Following the same rule, at 55 he would have +4 D. sph. for reading and at 60 +5 D. sph. In reality the calculation is rather in excess of what is necessary, and you will find that a +1 D. sph. added to the distance glasses for every seven years after 40 will be more accurate in practice. If the patient is myopic to an extent of one diopter, he will not require any glass for reading until he is between 45 and 50, and the same rule will apply in myopia as in hypermetropia, namely, that you add one diopter for every five years after 40 to the distance glasses.

All school children should be put under the influence of atropine for four to seven days and examined by retinoscopy at the end of that time. Children are often to be seen in the Out-Patient Department suffering from marginal blepharitis; these usually have an error of refraction and should be put under atropine.

Patients who are earning their living and are over the school age and under 40 are best treated by means of homatropine and cocaine, when a mydriatic is required, as the drug acts quickly and its effects pass off within a few hours, whereas atropine takes many days for its action to entirely disappear.

After the age of 40 no mydriatic is, as a rule, required, save in special conditions, and should never be used unless by the direct order of the clinical assistants or the surgeon, as an acute attack of glaucoma may be precipitated in a patient predisosed to intra-ocular tension, and the patient might be irrecoverably blinded by its action.

You will not, of course, imagine that these few remarks are at all complete or will enable you to deal with any but the simplest cases of refraction. I have endeavoured to imagine that you have only just entered the wards, armed with no special knowledge of the subject, with the exception, perhaps, of a little elementary optics acquired during your first year.

If you will take the trouble to consider carefully the points set down here you will not feel quite so much at sea when first you attend Ophthalmic Out-Patients, and also you will be able to render valuable assistance in dealing with the patients under the direction and supervision of the clinical assistants and the surgeons.

Specialities.

Pneumosan.

THIS preparation is an amyl-thio-trimethylamine compound. Its important constituents are methylene blue, valeric acid, and codeine phosphate. The compound has been tried as an injection in tuberculosis, and several reports have appeared which apparently show that it is of value in producing a marked improvement in the condition of the patient. An abatement of fever is recorded, and it is also reported that the opsonic index is raised. The product has been analysed in the *Lancet* laboratory, and the results are in accordance with the statements made as to its composition. The preparation seems well worthy of more extended trial and investigation.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

District Nursing.

DEAR SIR,—I want to put in a plea in favour of district nursing, which for some reason does not ho'd the place it should in the eyes of the average hospital nurse. One hears so often the almost unconsciously patronizing note in referring to this most important branch of work, "Oh, she is only a district nurse," or "sister, you don't mean to say you are taking up district nursing!"

To begin with, let me say at once, there is just as much medical and surgical work as midwifery to be found on the district, and under Mr. Lloyd George's scheme more and more acute cases are being nursed at home. It was in this "general" branch of the work that my friend and I found endless interest and fascination in one of the poorest and most over-crowded parts of the "dockers" London.

Secondly, I am convinced that no one who had once been a district nurse in a crowded slum, would ever again look down on the life. Granted that she has a love of poor people and can put up with a little hardship and dirt, her opportunities are absolutely unlimited, and there is nothing to compare with the life. She will find every atom of knowledge she has ever acquired absolutely necessary in order to run her district properly. We were each responsible for a district of crowded slum streets, stretching roughly over four or five miles, and in that area, of course under the doctor, our word was law. Acute surgical cases, accidents from the factories, undiagnosed tropical complaints, medical cases of every description, wasting babies, phthisis, everything was fish that came to our nets. Not only were we responsible for nursing them under exceedingly difficult conditions, but also for teaching our nurses how to enter a house, tackle the situation, often clear out crowds of sympathizing neighbours, and straighten a hopeless room, but more important still, leave with the words ringing in our ears, "dearie, you'll come again, its just like a bit o' 'evin." The gratitude and love these people give us, puts us to utter shame.

We joined a great training school for district nurses, where, passing through our hands, we had a steady stream of young country girls, who would eventually be put in charge of small country districts under the supervision of county inspecters. Each "staff," as we were called, was responsible for about four of these at a time, the most junior nurse always going round with her, the result being that one was able to give individual practical teaching to each one in turn. One had time and opportunity to find out all her strong and weak points

and the probationer felt, from the first day of her training, that her "staff" was her own personal teacher. I don't for one moment criticise our own hospital training, but we all know it would be a moral impossibility in the wards for the "sister" to have the junior probationer permanently tacked on to her apron strings. One remembers the glow of pride and importance when sister said "nurse, hurry up with your work and come and see this treatment." Space does not permit me to enlarge, but in many ways I maintain that the district nurse has many opportunities in her shorter and rougher training that her more favoured hospital sister lacks. It is immensely interesting to watch the development of a country girl into a level-headed, thoroughly useful, district nurse, though, of course, we have sometimes impossible material sent and dismal failures.

Then the people themselves are an unvarying source of interest. The children, affectionate little souls, making the best of everything, bubbling over with fun in the gutter, and taking the usual "no brekfus to-day, sonnie," as an evil too common to think twice about. It is worth anything to see their little faces light up when an unexpected bit of luck comes along: "a fardin's worf o' chips," or an old broken box; everything new is delightful. One enters a street to hear shouts of "'ere comes our nuss," and little grubs with bare feet and "farver's" trousers as their sole adornment, come surging round with the latest news of the neighbourhood, eager to hold "nusse's bike" or run an errand, or stand on their heads as occasion may demand. The district nurse is their friend, and one who is unresponsive to their chatter would indeed be out of place.

Then the grown-ups, what tragedies we find, met with pluck and patience past belief, and an unswerving faith in a better time coming. Everyone ready to lend a hand to those a little worse off than themselves. Dock hands, tramping day after day for the work that never can be found, women toiling into the early hours of the morning at some horrible sweated labour, just keeping off sheer starvation, nothing to put by, no hope for the future; we come in when sickness has brought the last crushing blow, and yet they will share the last crust with a stranger, or sit up night after night with a sick neighbour, after a day of slavery at a factory; and how often we hear, "Well, we mustn't grumble, nurse," when we in the same position would have been in stark despair.

We could tell you stories by the hundred which make one choke to think of, but if you want to see the best side of human nature, I say, try district nursing.

Kenwyn, AN OLD GUY'S NURSE.
Shawford,
Near Winchester.

The Fives Court.

DEAR SIR,—Some time ago a letter appeared in the GAZETTE regarding the Fives Court. We heartily agree with the writer, whoever he may be. Would it not be possible to cover the Court with glass (after even a shower it is impossible to play) and, perhaps, to light it artificially? If this could not be done, might a "squeegee" be provided for removing the water which is so often on the floor.

Many men would like to play, but when they have time either the court is wet, or—as your previous correspondent writes—the light is too poor.

We understand that the question of dressing-room accommodation is being considered by the Clubs' Union, but as action by this body is slow, if sure, the above appear to be alleviating measures that could be adopted forthwith.

We remain, Sir,
Yours sincerely,
"FIVES-PLAYERS."

Notices.

The Smith Turner Scholarship in Dental Mechanics.

ANNUAL VALUE, £30.

The Scholarship is founded: (1) To do honour to James Smith Turner's memory. (2) To help those students who, in the opinion of the Fund Committee, have financial difficulty in completing the Dental Curriculum.

The Scholarship is open to any registered dental student who has not completed the curriculum required for a dental qualification. The Scholarship will be awarded after examination, and tenable for one or two years, at the discretion of the committee. The Scholarship money will be paid to a Dental or a Medical School in Great Britain or Ireland, approved by the committee, in discharge of fees for any portion of the Dental Curriculum. The examination in Dental Mechanics will be both practical and *viva voce*.

The next examination will he held during April, 1914, at a Dental School, and on a date to be announced later.

Applications must be received on or before 15th March, 1914, addressed to the Secretary, British Dental Association, 19, Hanover Square, London, W. Printed forms for applications will be supplied to candidates.

Guy's Hospital London University Club.

The Annual Dinner was held on Friday, February the 20th, at Pagani's Restaurant. The President, Dr. John Fawcett, was in the chair, and about 40 members were present. After dinner, Dr. Fawcett proposed "The Club," and Mr. T. B. Layton, "The President." The attendance was too small to allow of the dinner being a complete success, but, at the same time, everyone was, we think, well pleased with the evening's entertainment.

Some Notes upon an Epidemic of Small-pox.

The City of Sydney has lately been going through an epidemic of a very mild type of small-pox, and as my work has taken me a good deal amongst it, I thought that a few personal notes might be of interest to your readers. I should state, in the first place, that Sydney, including an area of 10 miles radius, has a population of about 700,000. There is no Vaccination Law in the State of New South Wales, and at the time of outbreak the successfully vaccinated would not be more than 5 per cent. About 98 per cent. are of British and 99 per cent. of European race. There was a small outbreak here 30 years ago; it numbered 154 cases with about 40 deaths.

The present infection is thought to have been brought here from Vancouver (where there has been a similar mild epidemic) by a steward on a vessel trading between the two places. He is stated to have landed in New Zealand, which was also affected. He apparently had the disease in a very mild form, and so escaped detection. This man was seen later, and on being vaccinated gave the "mulberry excrescence" to be described. The attention of the Board of Health was first called to a clothing factory, the proprietor of which found that a large number of his girl employees were sickening with a rash and spots on face, etc. This had lasted over a month before he became alarmed, as the disease was thought to be chicken-pox, and so treated. When we came to investigate matters, many girls had returned to work, whilst others were sick at home. Those that had recovered only presented a few small marks on face and body, whilst of those sick some had the infection very mildly, but in others it was more marked and had spread to the palms of the hands and the soles of the feet.

As many as possible of these cases were vaccinated, and in no case did they show a normal vaccine vesicle. One of two things happened: either there was "no result" or a "mulberry excrescence" formed at the site of inoculation. This may be likened to a cheloid, of a cherry-red colour, and when once seen is highly suggestive of the person having lately gone through an attack of small-pox. The epidemic being of such a mild nature, and having had so long a start, has proved very difficult to eradicate. There have been up to the present 1,000 cases with only one death, and in that case it is doubtful if the disease was more than a contributory factor.

On the whole, young adults have been chiefly affected, although no age has been altogether spared. The old people seemed to be more seriously affected, and some of the most profuse rashes have been seen in patients over 60. Young children had the disease very mildly, some cases showing only 20 to 40 spots, although we were sure of the diagnosis. At the same time that the disease broke out, varicella was also prevalent, and when this occurred in adults it presented a problem of considerable difficulty to distinguish between the two diseases.

The following points were found of service: In *small-pox* cases the sequence of events was as follows: The patient complained of influenza-like pain in back followed in three or four days' time by the appearance of papules and pustules on the face; these spread quickly to scalp, ears, body, and limbs; the palms and soles were not affected until two or three days later. The rash did not go through the various stages of papules, vesicles, pustules, etc., but was pustular from the first. It was hard and shotty to the touch, this being especially noticeable on the wrists. Umbilication was not a prominent feature, as a rule, but in some cases it was well marked. The areola was circumscribed and only slight in many cases. The papules and pustules gave the appearance of being pushed up from beneath the skin, the resulting scales being raised above the surface of the skin; the small-pox rash, in fact, came out in crops.

In the *chicken-pox* as seen in adults, which was of a severe type, the prodromal symptoms were absent, or, if marked, the rash came out the following day. The body was nearly always affected first, vesicles were much more marked. The areola was diffused and oval in shape, and when occurring in the region of the ribs it tended to lie with its long axis parallel to them. The rash, although it might be well marked on the face and in the mouth, was of a more superficial character, and the scabs appeared early (three to four days) and lay flat on the surface of the skin. The mouth was affected in some cases, the ears seldom, and the palms and soles very rarely. In fact, the rash avoided the extremities, whilst in the severer small-pox cases these were always affected. The dome-shaped pustules, as seen under the thickened epidermis, were practically pathognomonic.

Bromide and *Iodide Rashes* were sources of difficulty, also *Syphilis*. In the early part of the epidemic I was totally deceived by a case I went to see at an asylum near Sydney. The patient had lately developed a rash and had during the previous fortnight been taking bromides. In this case the pustules on the face had a bright yellowish appearance. The rash was least marked on the body and limbs, with the exception of a patch on the outer side of the thighs. The small-pox rash sometimes comes out in clusters, especially on parts subject to irritation from garters or belts and on parts subject to pressure, such as the buttocks or the knees. I thing that the bromides taken had rather altered the appearance of the rash; later, when the drug was discontinued and the rash came out fully, her appearance was typical.

Another interesting case was one of variola and vaccine vesicles developing together. I vaccinated

the patient, a contact, on my first visit to the house; on my second visit, eight days later, she had three typical vaccine vesicles, also a commencing pustular rash on face. She went through the small-pox attack quite uninfluenced by vaccination. She was probably vaccinated on the fourth day of infection.

Several cases of suspected "variola sine eruptione" were also seen. I visited one family in which two or three members were affected. After I had taken down the history of prodromal symptoms, the mother said to me, "I think I must have had it, too, for I had symptoms like those myself." She was unvaccinated and never developed any rash. The type of disease as seen here had many differences from the disease as described in text-books and as seen in Europe and the East. Its low infectivity was well marked, the disease taking a long time to spread through a family. In one case a member of a family, working at the clothing factory mentioned above, was affected on the 16th of June. It was not until the 8th of July that the other members showed signs of the disease, although they were living in quite a small house and the first patient was not at all well isolated.

One of the worst early cases seen was that of an old man, aged 65, a South Sea Islander. He had the typical variola mask on face and a rise of temperature when the rash appeared. This "secondary fever" has been quite the exception in the present epidemic.

At one time during the epidemic we saw many vaccination rashes. These appeared any time up to three weeks after inoculation; they chiefly affected the wrists and face and resembled erythema multiforme with small bullæ, etc. The demand for lymph was so great during the commencement of the epidemic that sufficient time did not elapse for the added glycerine to kill out extraneous organisms. Later, when the Public Health Department made its own lymph we saw no more rashes. To show the extraordinary mildness of this epidemic, several pregnant women became affected and were safely delivered of living children either during or shortly after their illness. And yet anyone seeing the disease and its reactions to vaccination could not possibly deny that it was a true small-pox.

A curious factor in the history of small-pox is its relation to chicken-pox. The two diseases, apparently separated in the 17th century, had, in the 18th and so in Jenner's time, become confused again. It is strange in this connection that Jenner did not soon find exceptions to his statement that "those who had had small-pox could not be inoculated with vaccinia, and vice versa," since surely in some cases he must have been dealing with varicella when he thought it was variola. The death of the French King, Louis XV., of a second attack of small-pox (probably the first disease was really chicken-pox) would have drawn the attention of the profession, one would have thought, to the fact that there were two separate diseases at work.

It may be laid down as an axiom that the varicella is no bar at all to the patient being inoculated with vaccinia. Some little while ago there appeared some correspondence in the GAZETTE as to *Shingles* being a manifestation of chicken-pox in the adult. The only fact bearing on this point that has come to my knowledge is that a patient presented himself at the Health Department with chicken-pox and also a well-marked Zoster on his ribs.

In conclusion, I have to thank Dr. Payton, Director General of Public Health for permission to publish these notes.

J. H. JONES.

The New Clerk to the Governors.

Mr. C. H. Wells's Appointment.

ON Friday, February 13th, at a General Court, Mr. C. H. Wells was appointed Clerk to the Governors in succession to the late Mr. Henry Williams, who had held this important office for a very considerable number of years. The appointment is one of the oldest in connection with the Hospital, and in common with the posts of the physicians and surgeons, its institution came directly under the consideration of Guy himself, and was referred to in his will. It is the senior among the positions in the Hospital tenable by non-medical men, and Mr. Wells's promotion to it is a signal recognition of the confidence which the authorities have in one who has served the Hospital and School for many years.

Mr. Wells's first introduction to the Medical School was his appointment as Clerk to the Dean in 1880. At that time Dr. Frederick Taylor was Dean of the Medical School, being the first holder of that office. The thirty-four years that have elapsed since Mr. Wells became associated with Guy's have been years of great activity both in the Hospital and Medical School, and with the financial aspects of most of the changes that have taken place Mr. Wells has been intimately connected. His experience before coming to Guy's had been in association with banking in the City, and one of the first duties entrusted to him outside the routine work of the Dean's office was the re-starting of the GUY'S HOSPITAL GAZETTE on a sound commercial basis as its financial editor and manager. This work Mr. Wells has continued ever since, and the financial prosperity of the GAZETTE, which sometimes arouses the envy of other institutions in the School, is in large measure due to his judicious control of its business relations.

Dr. Taylor was succeeded in the office of Dean by Dr. (now Sir) Cooper Perry, and as Clerk to the

Dean Mr. Wells was soon taking his part in the numerous developments of the School which swiftly followed upon one another in the new regime. The erection of the Residential College, the foundation of the Dental School, and the commencement of the rebuilding of the Medical School Laboratories and Class Rooms were the chief events of this very active period of the School's history. About this time, too, the Students' Clubs' Union was formed by the amalgamation of all existing Clubs and Societies, including the GUY'S GAZETTE, and those who know the history of that time tell us that in the complicated arrangements connected with linking up the numerous financial interests and with negotiations for the purchase of the Clubs' Union Ground at Honor Oak Park the business ability of the financial editor of the GAZETTE was invaluable.

About this time Sir Cooper Perry relinquished the office of Dean of the Medical School to become Superintendent of the Hospital. As a result of the severe agricultural depression the finances of the Hospital were in a serious condition: 200 beds were closed for want of funds, and an increased revenue of £20,000 a year was required to set things right. In preparation for the appeal which it was determined must be made to the public for pecuniary aid, a new appointment of Secretary to the Treasurer was instituted, and Mr. Wells was chosen for the post, and has held the office till the present time. He has thus been associated with one of the most successful appeals for charitable assistance that has ever been made. Durthe last 19 years following upon the great festival dinner at which King Edward VII., while Prince of Wales, presided and at which contributions amounting to £166,000 were announced, more than one million sterling has been contributed to the funds of Guy's Hospital, between £300,000 and £400,000 being invested in the Re-Endowment Fund.

The wonderful development of the Hospital in this period of increasing financial prosperity is well known to most of those now taking part in the work of the charity. The familiar complaint of those who come back to the Hospital after being absent a few years that they cannot find their way about is indicative of the constant additions and alterations that have been made in recent times to bring the Hospital up to modern requirements. Mr. Wells has watched all these developments. He has helped the authorities to collect the money which has made them possible. His knowledge of every department of the Hospital and his enthusiasm for its welfare should prove invaluable in the responsible position to which he is now appointed.

Gazette Special Pathologist.

H. L., MANCHESTER.—This tumour is composed of interlacing bundles of cellular fibrous tissue, with abundant stroma and well defined vessels. It is a neurofibroma, and shows no evidence of malignancy.

Pupils' Physical Society.

A Clinical Meeting of the Society was held on Saturday, February 14th, Mr. A. Seabrooke in the chair.

Dr. J. H. Ryffel demonstrated a method of determining the amount of urea in the blood, and explained its importance in the diagnosis of uræmia. In answer to questions, Dr. Ryffel explained that the normal variations in value are slight, and that there is a slight increase for some hours after a heavy protein meal. All kinds of uræmia, in the clinical application of the word, do not give the same degree of increase in the blood-urea Eclampsia, for instance, shows usually only slight increase; but this condition is probably more a general toxæmia than a pure uræmic effect. In true uræmia the blood urea rises to not less than ten times its normal value.

Mr. J. G. Saner showed an interesting series of cases from the Massage department:—A case of neuro-mimesis, where a woman was unable to lift her arm, after removal of a cyst from the breast. Mr. Saner was able to furnish an explanation both of the etymology of the term, and of its pathology.

A case of lead palsy, involving the face and lower limbs as well as the wrists. Mr. Saner pointed out that for the successful treatment of lower neurone paralyses splints were far more important than electricity and massage.

A case of crutch paralysis.

Mr. W. R. Reynell: Bronchiectasis and fibroid lung, three years after an empyema operation, the wound of which had not healed. There was enlargement of the liver, thought to be due to amyloid disease. Dr. Mann thought that in the absence of anæmia amyloid disease might be excluded, and suggested that the palpable liver had been downwardly displaced by compensatory emphysema of the sound lung. Mr. Saner deprecated the satisfaction with which physicians, in a case of this kind, contemplate the appearance of lardaceous manifestations in one organ after another, while surgical intervention, however desperate, was still possible. Guy's were very behindhand in thoracic surgery.

Mr. C. W. Baxter: Amyotrophic muscular dystrophy. Dr. W. Johnson thought that as sensory changes were well-marked, the condition was more probably tuberculous pachymeningitis from spinal caries. The sensory changes were not those of syringo-myelia which was the remaining possibility.

Dr. W. Johnson: Amyatonia atrophica, associated with cataract.

Mr. D. Mather: A rare condition of the eye, apparently an innocent pedunculated growth projecting from the retina in the macular region.

Pass List.

University of London.

FACULTY OF SCIENCE.—D.Sc. EXAMINATION.
JANUARY 28th, 1914.

Chemistry: Richard William Merriman.

The 1912 Club.

THE first Dinner of this Club was held on Saturday, February 21st, at the Criterion Restaurant, Mr. G. Marshall in the chair. There were also present Messrs. Neville Cox, Depree, Edmund, Fox, Glendining, Heaton, Hind, Hunt, James, Lloyd, McNair, Montgomery, Mullally, Mutch, Parmiter, Sandison, Schlesinger, Trethowan, Vicary, and H. P. Warner. Mr. G. R. Hind was elected President for the next dinner, which will be held in February, 1915. Hon. Sec., Mr. T. B. Heaton.

Reviews, etc.

Gonorrhœa and its Complications. By Dr. Georges Luys. Translated and edited by Arthur Foerster, M.R.C.S., L.R.C.P. Royal 8vo., pp. xx.+384. (London: Baillière, Tindall & Cox.) Price 15s. net.

This work is an exhaustive monograph on gonorrhœa covering the subject from practically every medical standpoint, and also including more than a brief reference to the social and legal aspects of the disease. The etiology and history of gonorrhœa are very fully and frankly dealt with, as they should be, although we take leave to doubt one or two of the author's *obiter dicta* as to the prevalence of the complaint. For instance, we refuse to credit the statement that ". . . few men reach their prime without having had it once or more often."

The anatomical and pathological descriptions of the condition of the anterior and posterior urethra before, during, and after an attack of gonococcal urethritis are very clear and leave nothing to be desired.

In the sections devoted to diagnosis and treatment all the details of technique are fully described, but far too much space is given up to discussions on the relative merits of various instruments. Most of this might have been left out with advantage. There are several good plates of the appearance of the urethra through the urethroscope, and the volume is well illustrated. The translator has acquitted himself well, in that the English of the text is free from those solecisms and wrong idioms which so often deface translated works.

In response to a general demand, *The Prescriber* is now issued in a new form which contains many improvements and new features. The principal changes consist in a larger, and consequently less crowded, page; a type more suited for reading easily and at odd moments; enlargement and fuller treatment of the subjects at present discussed; the inclusion of certain new sections dealing with the latest developments in therapeutics and treatment. Arrangements have also been made for several special numbers to appear at intervals during the year.

Surgical Diseases and Injuries of the Genito-Urinary Organs, by Mr. Thomson Walker, is announced for immediate publication by Messrs. Cassell & Compy., Ltd.

A Manual of Operative Surgery with Surgical Anatomy and Surface Markings. By D. C. L. Fitzwilliams, Ch.M. (London: Baillière, Tindall & Cox.) Price 10s. 6d. net.

We do not think this book is a good one. It is written, as, indeed, the author confesses, not with a view to assisting the practising surgeon, but solely for the instruction of the student attending a course of operative surgery on the cadaver. It is, therefore, concerned primarily not with the operations of modern surgery, but with the detailed description of obsolete amputations and excisions, and the ligature of arteries never nowadays disturbed save in the operative surgery class. There is already a sufficiency of this type of book; what is wanted, is an operative surgery from which all the old and forgotten operations are purposely omitted.

Rugby Football.

GUY'S v. CAMBRIDGE UNIVERSITY.

Played at Cambridge on Wednesday, February 11th. Guy's were without Liebson, Kidman, and Guinness. For the last named J. P. Jones substituted, and right glad the Hospital were to avail themselves of the famous player's services. Cambridge had a strong side out, though Maynard and Lowe were not playing in view of the International on the following Saturday at Twickenham.

From the start Guy's pressed, the forwards putting in some sterling work and getting up close to the line. J. P. Jones dashed over and scored. Medlock's kick was not successful. A minor was then forced, the forwards being in good form, though kicking a bit too hard. Cambridge now got going, but play soon returned to mid-field. Here Mill was put in possession and made ground, but Millett played well and Cambridge were kept out. Wallace, failing to gather, let Steyn up, and he quickly took advantage of the opening to gain a try for Medlock to convert.

As soon almost as ends were changed Cambridge had the ill-luck to lose the valuable help of De Villiers, the South African International. But, strange to say, they played much better after he had been carried off, the forwards especially putting much more spirit into the game, and soon Norman got over for them, Wallace adding the extra points. Guy's scored again soon after, Curle getting the ball from a cross kick intended for Zeigler. Curle got a try wide and no conversion followed. Wallace, after good three-quarter play, added another try for the 'Varsity, no goal resulted. But soon after Wallace sent Wilson in, and as the former goaled, Cambridge led us by 13 points to 11. The Hospital did their utmost to score again, and though they came very near doing so on several occasions, the 'Varsity defence held, and a very close game ended in favour of Cambridge.

After De Villiers' injury Wallace went three-quarter, Symington to full-back. Scores :—

Cambridge University, 2 goals, 1 try ... 13
Guy's Hospital ... 1 goal, 2 tries ... 11

Teams. GUY'S.—H. Millett (back); *S. S. L. Steyn, *J. P. Jones, A. H. Harkness, C. L. Curle (three-quarters); L. R. Broster, C. H. Medlock (halves); C. S. Lane Roberts, O. Parry-Jones, A. B. Danby, M. B. Tweed, E. F. Llarena, C. H. Laver, J. Shelswell, W. Whitworth (forwards).

CAMBRIDGE UNIVERSITY.—*W. M. Wallace (back); G. G. Zeigler, W. H. B. Baxter, *D. de Villiers, *J. G. Will (three-quarters); *J. C. M. Lewis, A. C. Waddy (halves); *A. W. Symington, A. H. Wilson, R. Juckes, A. Vintcent, W. D. Doherty, C. McUre, J. H. C. Lindesay, J. Norman (forwards).

* Internationals.

GUY'S "A." v. OLD CHARLTONIANS.

KENT CUP.—FIRST ROUND.

This match, played at Honor Oak Park on January 31st, 1914, resulted in a victory for Guy's by 2 goals 1 try (13 points) to 2 goals (10 points). The day was fine and the ground in excellent condition, but a strong wind blew across the field. Old Charltonians kicked off, but Day-Lewis returned well. Fine passing by Guy's three's saw Mackenzie get well away and put Shellswell in with an inside pass. The kick failed. From the drop-out Shellswell secured, and running with great determination, passed to Gie, who scored. Whitworth converted. Another fine passing movement by the threequarter line saw Crook run in under the posts, Whitworth converting. Half-time then arrived with Guy's leading by 13—0 points. During the second half, Guy's slackened considerably, and Old Charlton scored 2 tries, which were converted, Guy's thus winning as stated.

REMARKS.—The team as a whole played well, but must remember to go for the man with the ball. This fault was very noticeable both among the forwards and outsides.

GUY'S "A." v. SIDCUP.

KENT CUP.—SECOND ROUND.

This match, played at Sidcup on February 7th, 1914, resulted in a draw, each side scoring a try. The weather could not have been worse. Rain descended in torrents the whole afternoon, and, in addition, a strong wind blew straight down the field. Under these conditions, good football was impossible, the ball resembling a piece of soap, and being very difficult to control, even with the feet. In the first half Sidcup played with the wind and scored an unconverted try. Our forwards invaded their half several times, but could not pierce a sound defence. With the wind in their favour during the second half, Guy's were almost entirely in their opponents' half, but could only score one unconverted try through Crook, who played a fine game. There was again a noticeable reluctance to go for the man with the ball. This must be remedied.

GUY'S "A." v. SIDCUP—(REPLAY).

KENT CUP.—SECOND ROUND.

This match was played at Honor Oak Park, when the home team ran out winners by a goal and 6 tries (23 points) to nil. The conditions were again wretched, but there was no wind. Guy's, however, rose superior, and played a splendid game, the forwards wheeling and rushing magnificently, and the tackling all round showing marked improvement. Special mention must be made of Anthony, who was always on the ball, and scored 4 of the 7 tries. Both wings, too, ran well, and the handling of the outsides would have been creditable on a dry day. The second fifteen have now not lost a match since October 18th last, and have only drawn one. If they play as they did to-day there is no reason why they should not secure the Kent Cup and retain the Junior Inter-Hospital trophy, but for this every man must keep as fit as he can. It was very encouraging to see several supporters on the touch-line, including a member of the staff, and much of the team's success must be attributed to these gentlemen, who made up in volume of sound what they lacked in numbers. May we see them again in our future engagements!

GUY'S "A." v. ST. THOMAS'S HOSPITAL "A."

INTER-HOSPITAL JUNIOR RUGBY CUP.—FIRST ROUND.

Played at Chiswick, February 18th, 1914, and resulted in a win for the holders by 3 goals and 2 tries (21 points) to nil. Tries were scored by Knott, McEvedy, Mackenzie, and Crook, but the team did not give a convincing display, and have not cured themselves of that disinclination to go for the man with the ball, which is fatal. In this respect St. Thomas's were much superior.

GUY'S v. LONDON.

2ND ROUND, THE HOSPITAL CUP.

For the first time for many years the draw ordained that we should, if London and ourselves were successful in the first round, meet in the second round. It was a nasty day with a diagonal breeze and persistent rain. When the sides lined up at Richmond on February 19th it was noticed that Kidman was unable to turn out. Whitworth took his place. Guy's had the best of the opening stages, but no score resulted; the forwards worked very hard, but the backs, with the exception of Broster and the two wingmen, did not make much use of what few chances came their way. For a long time the game was kept very close indeed, hard scrummaging all the time. At length London got away with a loose dribble, and Millett was forced back beyond his line, but he punted well out of danger, Curle doing the same thing just after. Our forwards returned to well up the field, Roberts playing splendidly. Stewart then fumbled and Medlock tackled him instead of going for the ball, and a "free" being awarded,

London got a lengthy kick to touch. Guy's after another ten minutes were pressed to their 25, and from a scrum Powell picked up and made his way over the line for a try. Batchelor missed the easy place. Guy's were almost drawing level just after, first Danby was held close in, and then Broster, who had Steyn next him unmarked, had the ill-luck to send a pass over Steyn's head. Half-time arrived with Tweed crocked, and only able to hobble about, but he pluckily persevered till the very end.

Less than ten minutes after resuming London were awarded a free kick (a rather severe penalty on our forwards for the offence which looked an ordinary off-side), and Batchelor kicked a very fine goal, the ball hitting the bar and bouncing the right way for London. Still Guy's persevered, but I think we kept the game too tight being points down. Our three's had very few opportunities; and surely London's scrum half was offside repeatedly. This prevented Broster getting the ball away till late in the game, and then, alas, the most promising movement ended disastrously for us. Passing had gone neatly till Harkness gave the final pass, yards behind Curle, who could not get back before Stewart, the Scotch International picked up and dashed away for a try right behind the bar. Batchelor goaled and this ended the scoring. Guy's never settled down to their proper game, and played all through as if the occasion was too much for them. Roberts, Parry-Jones, Laver, and Llarena, of the forwards, were very good, the first named splendid. Broster tried his very utmost under great difficulties. Steyn and Curle did all they could. Millett was very fine indeed. He tackled with the utmost fearlessness, and his touch finding and ground work were beyond reproach. Without appearing presumptuous I should like to add a word of real admiration for London's three forwards, L. G. Brown, M. P. Atkinson, and J. R. Dew. The first named gave an exhibition of forward work which has seldom if ever been excelled. Final score: London, 1 goal 1 penalty goal 1 try, 11 points; Guy's, nil.

REMARKS. — It was bad luck for that brilliant player, C. S. Lane Roberts, that the year of his captaincy should be the one for us to temporarily lose the cup, but he may take important note that no man could have done more than he did in attempting to retain it. It simply wasn't our day out, or else it was very much London's. We did not look like a winning side except ten minutes before half-time, and our light did not shine very much after Batchelor kicked his penalty. Roberts may take comfort from the fact that the greatest player Guy's ever had behind the scrum, E. Morgan, was captain in 1904 when London defeated us, though that year we had a really magnificent side. Again in 1906 we lost to London, but that year was a lean one for us. F. Alcock was the captain, and many good men went down during 1905. Then 1908 arrived with J. P. Jones, a captain among captains, but even his genius was not sufficient to stem defeat, though Jones had an excellent side at his command. If my memory is correct we shall not again see C. S. L. Roberts, C. H. Medlock, and A. B. Danby in these competitions. They retire and carry with them the gratitude of all Guy's men. The two former did not play in the Cup Team the first year they were at Guy's, but both have played in the five successful years since 1908 as well as on the present occasion. It is rather a pity that the last and sixth year of their appearance has not carried on a stage further the foregoing successful sequence. To have played in the victorious Cup Tie team for six years in succession would have been a great achievement, but the next best thing to six is—five.

GUY'S v. COVENTRY.

This match, played at Coventry on Saturday, February 21st, following so closely on our hard encounter with London on the 19th, found our ranks somewhat depleted. Roberts, Millett, Tweed, and Kidman could not make the journey, neither could Harkness, for whom J. P. Jones kindly deputised. The places of the forwards were taken by men from the 3rd XV., as the second team was engaged at Honor Oak Park in a Kent Cup Tie.

The game was a fast and open one, and very few minutes elapsed before Muddiman gained a try, just beating Guinness in a race for the touch. Hall converted, and then Hawkes got another try for Coventry which went unconverted. After this double reverse Guy's got together better, and after some very fine passing Curle got a try by the posts which Medlock easily increased to 5 points. This was all the scoring up to half-time.

Guy's resumed with much energy, but unluckily we were penalised in front of goal, Hall having no difficulty in goaling. The Hospital did not get going again until after Owen had put Coventry further ahead. Then all our backs handled very smartly on several occasions, but the defence held until after several attacks we just managed an unconverted try in the corner. Coventry lasted rather the better; our men began to feel the effects of their heavy mid-week match before the end, and Coventry got two more tries. Final score: Coventry, 2 goals, 1 penalty goal, and 3 tries, 22 points; Guy's, 1 goal 1 try, 8 points. Team:—

GUY'S.—A. F. Guinness (back); S. S. L. Steyn, L. R. Broster, J. P. Jones, C. L. Curle (three-quarters); J. Thom, C. H. Medlock (halves); O. Parry-Jones, A. S. Liebson, A. B. Danby, C. H. Laver, E. F. Llarena, B. Laver, J. B. Monk, L. J. Vilgeon (forwards).

Death.

GARDNER.—On February 15th, at 276, Earl's Court Road, S.W., John Twiname Gardner, M.R.C.S., L.R.C.P., aged 59.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE note with much pleasure that the names of three Guy's men appear in the recent list of new Fellows of the Royal Society. The names in this list, which are of particular interest to Guy's men, are those of Dr. Lowry, Dr. Assheton, and Dr. A. E. Boycott. We heartily congratulate all three gentlemen on the honour which has been bestowed upon them, although it was, as we need hardly say, a well deserved and not unexpected one. The eminence of Dr. Lowry as a chemist, of Dr. Assheton in the field of embryology, and of Dr. Boycott in experimental pathology, is such that sooner or later each was assured of the recognition now forthcoming. Dr. Assheton and Dr. Boycott have both unfortunately severed any direct connection with the School, Dr. Assheton to pursue his work at Cambridge, and Dr. Boycott to fill the chair of Pathology at Manchester. Dr. Lowry is, of course, still Lecturer on Chemistry in the School, and is the only member of the present School Staff who has attained the coveted distinction of being an F.R.S.

THE Park was favoured last year by a quite unexpected addition to its fauna in the shape of a pair of rooks. The strangers, who appeared early in March, took up their abode in one of the trees overhanging Clinical, and proceeded to build themselves a nest—rough but serviceable, as is the custom of their tribe. In due course a pair of young rooks appeared, and as soon as they were able to fly the whole family departed as mysteriously as they had come. Their presence excited, of course, a good deal of interest, and there were many speculations as to the causes which had led them to choose so apparently unlikely a spot for their mating. One suggestion which found favour was that they were a pair who had for many years nested in the trees in Gray's Inn, and who were noticed to be absent from their old haunt last year. The reasons which led them to abandon the precincts of the law in favour of those of a hospital form matter for interesting if idle supposition. It is curious, also, that this particular pair should have departed from the habits of their kind, and elected to lead a solitary life instead of throwing in their lot with a colony of their fellows.

There was naturally much curiosity to know if the rooks were satisfied with their quarters and would again visit us this year. Apparently they were not displeased with last year's experiment, since they appeared again about a week ago, and have already laid the

foundations of a fresh nest. This time they have chosen one of the trees near the main entrance to Hunt's House.

We are very pleased to learn that the Residents have decided to revive the old custom of Smoking Concerts in the College Dining-room. It must be several years since the last one was held, and many of us have been sorry that the custom was falling into abeyance. They are always thoroughly enjoyable functions, affording a welcome change to the dull hospital routine. The date of the forthcoming concert has been fixed provisionally for April 30th, the Residents' "Going-off" day. It is hoped that Dr. A. Allport will take the chair, and that a large number of past and present Guy's men will turn up. We hear that several old favourites have already promised to entertain us, and we feel sure the evening will be a complete success.

The Residents have recently greatly improved their quarters by providing themselves with a very comfortable Common Room. The Junior Charity's room, with the adjoining Extern's bedroom, have been knocked into one fairly large room, and a parquet flooring put down. The old drab wall-paper has been replaced by a tasteful brown, and suitable lights have been installed, with the result that past generations of Residents would never recognise in this bright and handsome room the dingy quarters where they foregathered for coffee in the evenings.

Through an oversight we forgot to mention last month that Messrs. W. Robinson and R. C. Ozanne had been elected respectively President and Vice-President of the Residents.

It has long been a matter for complaint that the average man did not in nine cases out of ten hear the pathological report on specimens sent for microscopical section from the post-mortem room, and to a lesser degree from the operating theatre, and to all intents and purposes he never had the opportunity of personally looking at the section. No doubt if he was sufficiently keen, and had a long memory, he could have worried it out during the following week by enquiring in the pathological laboratory, but most of us were not particularly interested and simply forgot all about the matter. We are very glad to hear, therefore, that the way of the enquirer is to be smoothed for him. In future sections of specimens sent from the post-mortem rooms and operating theatres will be shown, during the week following their removal, in the class room in the Pathological Building. Microscopes will be provided and the sections will be easily accessible. The scheme is, we think, an admirable one, and will enable every man to correlate his clinical observation with both morbid anatomy and histology and thus obtain a clearer picture of disease. We presume that the specimens will also be available for demonstration by the teachers of morbid anatomy, who will then be able to drive home the significance of naked-eye changes.

The next meeting of the Physical Society will be held on Wednesday next, March 18th. It is a Pathological Evening, and the specimens will be shown as usual in the Wills Library. The closing meeting of the session will be held on March 28th, when Mr. Steward will announce his award for The Treasurer's Prize Essay on "Surgical Shock." It is hoped there will be a large attendance at both meetings, so as to enable the Society to maintain the good record it has so far had during the present session.

We are asked to state that a Special Service for Members of the University of London will be held, as in the past six years, at 6 p.m., on Presentation Day, May 13th, in Westminster Abbey. The Sermon will be preached by the Lord Bishop of London. Admission to the Abbey will be restricted to Graduates and Undergraduates of the University who present tickets. Application for tickets should be addressed to the Secretary of the Westminster Abbey Service Committee, 88, Gower Street, W.C. A stamped addressed envelope must be enclosed.

Ralph Wingent Memorial Fund.

THIRD LIST OF SUBSCRIPTIONS.

	£	s.	d.
A. E. P. Cheesman, H.M.S. *Woodlark*, China Station	0	10	0
"The 1912 Dining Club," per Trevor Heaton	1	2	0
Alfred W. Ewing, Puckeridge, Herts. ...	1	1	0
C. H. Fagge, Devonshire Place, W.	1	0	0
E. Austin Penny, I.M.S.. 14th Jat. Lancers, Risalpur...	0	10	0
John Ryle, additional	0	10	0
	4	13	0
Previously acknowledged (Feb. 7th, 1914) ...	14	10	6
Total	£19	3	6

March 10th, 1914.

H. C. MANN,
P. S. PRICE,
Hon. Secs.

Papers by Guy's Men.

Goodhart, Sir James F., Bart., M.D., F.R.C.P.: A Lecture on Glycosuria and the Albuminuria of Adolescents.—*Lancet*, March 7th, 1914.

Gilford, Hastings, F.R.C.S.: The Hunterian Lectures on Infantilism.—Lecture I., *Lancet*, February 28th, 1914; Lecture II., *Lancet*, March 7th, 1914.

Maylard, A. E., M.B., B.S.: The Fate of a Plug of Iodoform Gauze accidentally left in the Abdomen.—*Lancet*, February 28th, 1914.

Shufflebotham, F., M.A., M.D., J.P.: The Milroy Lectures on the Hygienic Aspect of the Coal Mining Industry in the United Kingdom.—*British Medical Journal*, February 28th and March 7th, 1914.

McGavin, Lawrie, F.R.C.S.: Two Lectures on Spinal Analgesia.—Lecture I., *Clinical Journal*, March 11th, 1914.

Jordan, Alfred C., M.A., M.D.: A Note on Chronic Intestinal Stasis.—*Clinical Journal*, March 11th, 1914.

Pass List.

University of Oxford.

DEGREE OF D.M. CONFERRED.

F. O. Stohr.

University of Cambridge.

M.B.

A. C. Clifford. | J. M. Jarvie.

M.B. DEGREE CONFERRED.

E. S. Taylor.

An Abstract of an Address on Homœopathy.

Delivered before the Pupils' Physical Society by Dr. C. E. Wheeler.

It is frequently believed that homœopathy makes exclusive demands upon its votaries, binding them into a narrowed sect and forbidding them to practise any branch of medical art beyond the prescription of minute doses. This is a complete misconception, and it cannot be too often insisted that homœopathy does not preclude the use of any other method of treatment. It should be regarded solely as yet another weapon in our armamentarium against disease. The homœopathist does not deny that the orthodox practitioners of medicine have many valuable methods for use in disease, but he believes that, in so far as concerns the therapeutic application of drugs to diseases, he has an additional method so far superior to those of orthodox medicine, and so widespread in its application, as largely to supersede the other methods. The resources of surgery, of light and heat and electricity are known to and used by the homœopathist, who would describe himself as one who desires to know all there is to be known of ways of relieving the sick.

Before considering the special obstacles that impede the spread of homœopathy, it is, perhaps, advisable to attempt to show its central doctrine under an aspect more suitable to modern conceptions of disease and life than appears at a first view.

Life is inextricably associated with the activities of protoplasm. Protoplasm is remarkable for its power of modification of activity under different circumstances for its power of reaction to stimuli. It can, however, be destroyed by thermal, electrical, or chemical agents if they are applied in sufficient intensity.

Now the resistance of the system to noxious agents is one that varies in detail, but is always fundamentally a question of increased activity of some or other of the body cells. The postulate of the homœopathist is that every agent which can damage or destroy a cell can, if administered in a sufficiently small dose, act as a stimulus to the activities of that cell. This is true of the effects of electricity on the amœba, and another example can be found in the clinical application of X-rays. It is well known that excessive exposure to these rays has produced inflammations of the skin, and even cancer, yet they are habitually used in modified doses to cure or relieve cancer. Similarly they are used in small doses to promote the growth of hair, although long exposure to them will destroy the hair. These are simple applications of the principle that the agent which in excess destroys, in reasonable measure stimulates. But there is no reason to doubt that if this be a law of protoplasm governing its power of reaction, it will apply also to chemical stimuli—in other words, to the effects

of drugs and bacterial toxins. These principles, indeed are embodied in the biological laws of Rudolf Arndt which are not questioned in the realm of biology.

Disease, whether bacterial or non-bacterial, consists n a struggle of certain groups of cells against a chemical or other enemy, and the symptoms of the disease are the evidence both of the attacks and the defence. The problem for the physician is obviously to aid the defence; clearly if it were possible to give an extra stimulus to the particular cell groups that needed it, the net result should be a reinforcement of the powers of resistance. If, however, a drug that is a poison in a large dose is a stimulus in a small, if we know that a poison has a definite affinity for the cell groups that need assistance, then the administration of a small dose of that poison should aid those cell groups in their labour of defence. This is the expression of the homœopathic law.

The final test of the homœopathic principle lies in direct personal experience. If the physician knows the symptoms drugs can produce in the healthy, then he can watch drug symptoms with disease symptoms, and find out for himself if the rule of selection advocated by Hahnemann is justified by its results. This appeal to the individual is the only convincing one. It is one, however, that was refused in Hahnemann's day, and the refusal has been largely continued to the present day.

This bitterness and prejudice are unworthy of the scientific mind, and their continuance make it difficult for any man to apply the test of personal experience, the most conclusive one for the actual practitioner. There are, however, some general suggestions, the consideration of which may make the doctrine of homœopathy less unattractive. The only proviso that must be insisted on is that no amount of refutation of theoretical argument can counterbalance or replace the practical test.

If any considerations in favour of homœopathy seem to the physician unfounded let him by all means reject them, but let him also remember that the results of practice can only be refuted by other and different results; and unless he is better pleased with the weapons of modern medicine than appears from most statements of authority he is less than just to himself and his clients if he neglects any suggestion for improving them.

It must be remembered that in all the countries of Europe the physician who adopts homœopathy has had previous experience of the fruits of the different school of treatment. His knowledge and his skill remain constant factors, and if he is convinced that he gets better results following Hahnemann than following the methods he has been taught, to what can he attribute the improvement, except to the efficacy of the new law he has come to recognise? Each homœopathist says: "I get better results from the one method than the other, and I have tried both." This is direct evidence and it is all the stronger since confession of this faith involves more or less professional ostracism and contumely. The strongest part of the case for homœopathy is that its practitioners are so often men who have been converted from the ordinary methods, in spite of the price exacted for conversion.

There are only three possibilities. Firstly, that they are honestly mistaken. But how can this be decided by men who have not made the necessary experiments? Secondly, that they are not convinced, but pretend to be—that they are knaves. The only arguments used are theoretical, and the difficulty of accepting this explanation is enormous. The genuine charlatan is notoriously a solitary soul, but homœopathists form societies and seek companionship. Further, why, if their aim is fraud, should they burden their lives with the task of mastering the intricacies of drug action? Let no man delude himself that it is an easy matter to practise homœopathy. If it is a fraud, why build up this elaborate structure for the sake of unnecessary toil? The explanation becomes absurd. There remains the third possibility that they are right, that they do get better results, and that they are repaid for ostracism and contempt by increased power over disease.

A difficulty in the path of homœopathy consists in the prejudice that so surrounds the name that investigation of the truth requires not only energy but courage. Although the experience of a hundred years has modified the apparent unreasonableness of the doctrine, the hatred aroused at its first statement clings about it, and a man may well hesitate when even to investigate the question is regarded as tampering with an unclean thing. However convinced a man may be that homœopathy is founded on an error, it is sheer bigotry to make enquiry difficult or impossible.

A more formidable problem for the enquirer is the association of homœopathy with infinitesimal doses of drugs, nor is there any candour in denying that it is a stumbling block to the mind trained to ordinary conceptions of matter. That *small* doses can produce effects will now be hardly contested. Not only mercury, but quinine is habitually used in smaller quantities than in bygone years. Yet how many can resist the belief that if one grain of a drug does good, five grains will do more good? Nevertheless, common sense would suggest that as drugs are poisons more or less, virulent enquiry should be directed to determine how *little* of a remedy will produce an effect, not how *much* the patient can endure without succumbing. It is one thing, however, to use small doses, but to make the step from small to infinitesimal is more of an undertaking. Nor is it an essential feature of homœopathy, many convinced followers of Hahnemann have never used the infinitesimal doses, and no man need refuse to investigate homœopathy because some homœopathists use infinitesimals. Let him begin with doses as material as he pleases.

Finally, there is a serious obstacle to the progress of homœopathy in the extreme difficulty of practising it well. No man can fairly test it in less than a year, because he ought to try it throughout a considerable range of cases, and needs some months of study to equip himself for the task. Fortunately, however, the acuter

diseases are generally easier to deal with, and, as a general rule, it is better to try homœopathy first in the acute cases.

The renewed confidence which faith in homœopathy gives must be experienced to be believed; men who in despair have abandoned drug treatment as useless when not harmful, have found joy and justification for the confidence of their patients in the results that follow the careful application of Hahnemann's law. The task is severe, but the reward is great. The struggle with death must always in the long run be a losing battle, but in the effort physicians make to win a partial and temporary victory there is support in knowing that no avenue to success, however apparently unpromising, has, through sloth or prejudice, been abandoned without investigation.

Notices.

Royal Army Medical Corps.

ENTRANCE EXAMINATION.

An examination for not less than twelve commissions in the Royal Army Medical Corps will be held on the 29th July, 1914, and following days.

Applications to compete should be made to the Secretary, War Office, not later than 20th July, 1914.

The presence of candidates will be required in London from the 27th July, 1914.

A copy of the regulations for admission to the Royal Army Medical Corps and a form of application can be obtained on application to the Secretary, War Office.

Change of Address.

W. G. Brett, M.R.C.S., L.R.C.P., to Grand Hotel de Londres, San Remo, Italy.

M. Fred. Hopson, L.D.S., to Box 8, Queenstown, Cape Province, S.A.

R. S. Kennedy, from Ophthalmic Hospital, Dekemes, Lower Egypt, to c/o Public Health Department, Cairo, Egypt.

Dr. W. Gibson Parker, to Belmont, Ashcombe Road, Weston-super-Mare.

Gazette Special Pathologist.

W. J. L., Herne Hill.—This specimen is infiltrated by a malignant growth composed of alveolated masses of epithelial cells and having the general structure of a spheroidal-celled carcinoma. A portion of stomach wall can be recognised, showing the growth and much inflammatory change.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Private Nursing.

Dear Sir,—The inspiring letter in your last issue in favour of "District Nursing" will probably call forth many recruits to join that most excellent branch of the nurses' work. At the same time I think "Private Nursing" should occasionally be put before the "best" nurses who are about to leave hospital to take up a useful stand somewhere on the rank.

The first great drawback on leaving hospital is the loneliness which is very acute but even that is softened by the kind of case one is at, and fortunately (like most of the unpleasant things of this life) one gets used to it, especially if one can easily become interested in new surroundings, and likes plenty of change; again, with another nurse, especially if she is one of "our set," time passes very quickly, particularly outside the patient's room.

I can hear a nurse say "I should be so nervous." Yes, nurse, so was I, but believe me you learn more as a private nurse than ever you did in hospital, especially when you have had a few difficult and exacting patients; and, of course, they are not all easy, especially at first. However, you can always ask to be changed, and the Superintendent's final word after hearing all is usually, "never mind, nurse, better luck next time."

Patients (with very few exceptions) are extremely grateful, and if you study them they will look after your comforts in every way.

After all, if none of the "best" nurses take up private nursing it is hard lines on the public who are willing to pay, each one wanting the best nurse that can be obtained.

T. M. MADDISON.

Guy's Institution for Trained Nurses,
14, St. Thomas's Street, S.E.

Sir,—The "Dr. Wade Memorial Library Fund," having reached the required amount (£40), is now closed. The books have been placed in the Chemical Laboratory, and are available for use by any member of the School.
—We are, yours truly, M. S. PEMBREY.
R. W. MERRIMAN.

The Dental Society.

Eruption of Incisor Tooth into the Nasal Cavity following an operation.

By R. OROZCO-CASORLA, L.D.S. Eng., San José, Costa Rica. Communicated by Mr. W. A. MAGGS.

The right upper incisor, as shown by the photograph, had erupted into the nasal cavity. The tooth, owing to the shortness of its root, was removed without difficulty under novocain. The tooth itself presented a pit at its cutting edge.

The patient, aged nine years, an American-Indian girl of a Costa Rican tribe, had been operated upon five years previously. The operation was said to be necessary in consequence of an injury to the lip and jaw due to a fall.

CASE I.

Note by Mr. W. A. Maggs.—He reported that the mal-position of the tooth was clearly due to the operation, but it was difficult from an examination of the model and of the photograph to believe that the condition requiring the operation was occasioned by accident. The position of the fissure through the lip and the palate indicated congenital cleft palate. However, Mr. Orozco-Casorla had reiterated that the child was normal previous to the accident.

Mr. R. Keith Common, L.D.S. Edin., has recorded a case of "Eruption of Central Incisor in Nasal Cavity following operation for Cleft Palate." (*Vide* "Items of Interest," vol. xix., 1897.)

The models and photograph of Mr. Orozco-Casorla's case were presented to Guy's Museum, and the published reports from "Items of Interest" referring to Mr. Keith Common's case was read.

Eruption of Central Incisor in Nasal Cavity following operation for Cleft Palate.

By R. KEITH COMMON, L.D.S. Stirling, Scotland.

The accompanying photograph shows a remarkable result of misplaced alveolar process in an operation for cleft palate. The patient, a boy of ten years, was operated on twice by Sir George Macleod of Glasgow: first when three months old, and again at fifteen months.

CASE II.

The fissure which extended through the lip, hard and soft palates, was remarkable for its width and depth, and there was considerable difficulty in overcoming the tension in uniting the lip. The alveolar process was drawn together, but no attempt was made to close the parts behind as it did not promise to benefit his speech. In a year or two an obturator will be made, and this is expected to give a better result.

In approximating the edges of the process, that part

containing the right incisor tooth had been tilted upwards, and of course changed the direction of the growing tooth with the result seen in the photograph. Soon after the second operation, a small hard nodule was felt in the floor of the right nasal cavity, which was thought to be bone, but proved after it dropped out to be the right temporary incisor.

The permanent tooth made its appearance only a few months ago, and its eruption was very rapid, taking an upward and outward course, with its mesial edge anteriorly. On removal of the tooth, which came away very easily, its appearance showed that its formation must have been disturbed at the time of the operation, a distinct depression encircles the crown about its middle, giving the appearance of a united fracture.—"Items of Interest," vol. xix., 1897.

Spirits in Prison.*

Through all ages the imagination of the poet and reformer—are they not one?—has been held by the thought of humanity in captivity.

Deeply rooted in all living things is the passionate desire for freedom for the body and the finding of a way for the mind.

Limitations placed upon these natural instincts speak of frustration and perplexity. From the churches of our nation the petition has long been raised "for all prisoners and captives."

Here comes a woman to tell us of the land where they dwell. Of the cause which led her there we need not now speak. You may class her as a fanatic and pass her by. There is, however, history behind us to teach that the despised and discredited of one age may become the saviours and revealers of the next.

The central idea of Lady Constance Lytton's book is an overwhelming sympathy with failure and sorrow and wrongdoing.

Long before her own prison experience she had felt deeply the hardships and stupidities of our penal system. Writing to her mother, she says, "Prisons, as you know, have been my hobby. The maternity that lurks in me has for years past been gradually awakening over the fate of prisoners, the deliberate, cruel harm that is done to them, their souls and bodies, the ignorant, exasperating waste of good opportunities in connection with them, till now the thought of them, the yearning after them, turns in me and tugs at me as vitally and irrepressibly as ever a physical child can call upon its mother."

Most crimes are the result of a lack of self-respect. This is realised in the dedication of the book "To Prisoners."

The author pleads with her fellow sufferers (not those condemned for reasons political) to lay hold of an inward self and reverence that as the only way of escape from all that is helpless, selfish, and cruel in their present apparent self. The prison system is concerned only with their failings. She writes: "I felt mentally stunned, physically cowed, morally indignant." A strong spirit is needed to survive such sensations. The whole question is studied apart from herself only with a view to its effect on those she describes so sadly as "real prisoners."

While giving full allowance and gratitude for all kindness and humanity met with during her imprisonments, Lady Lytton sees that the weight of routine crushes alike the official and the prisoner. In one telling passage she describes, for instance, the curious custom by which "this and all other rules of the kind would hardly ever be told to us in so many words, but suddenly the wardress would step out and block the way, laying her hand upon us without a word, as if we were animals. This being handled when there is no occasion for it seems very insulting. Like all these prison methods, it seemed curious and interesting when first done to oneself, but aroused a feeling of indignation when one saw it being done to others."

Like a ray of light her sympathetic insight discerns in the gloom of this under-world the natural kindliness of the women one to the other. The similarity of fate was a bond.

For years the sight of a prison van had filled her mind with "an almost maddening craving" to know of the women inside. How and why had they broken laws, in what way were they enemies of society. Above all how could society help them back again to paths of honour.

The journeys she took in the fateful vehicles as Constance Lytton and Jane Warton, bring her questionings for answer to our own hearts.

To many the most striking part of the book will be the appeal to women of the author's own class. The walls of their prison are invisible, but none the less impassable. Convention, prejudice, and custom, shut them off from the knowledge of men, women, and children, who toil and suffer.

"The weakest link in the chain of womanhood is the woman of the leisured class" is a strong statement. Lady Constance Lytton speaks from her own life and experience, and is thus well qualified to point the way to the freedom of service. She pictures these women enduring the labours and penalties of their superficial and dependent lives, an endless procession concerned only with social exigencies and appearances. In contrast she depicts the prisoners exercising in single file in the Holloway Yard.

It is a procession of failures too often the result of struggle against superior and unbending forces, containing, however, something of humanity and dignity lacking in that other group.

Placed beyond the hope of purgatory and at the gate of hell are

> "The sorrow-smitten souls of those whose name
> Nor foul reproach nor glorious praise did share."

We are taught that woman stands to lose her essential attributes in her pursuit of knowledge and her interest in things political. These things are but a way to an end. The cry of humanity at large has reached her, and she would extend her succour to all appealing for her help including all prisoners and captives.

* "Prisons and Prisoners." By Constance Lytton and Jane Warton, Spinster. (William Heinemann.) 3s. 6d. net.

Radium.

CLINICAL LECTURE BY DR. IREDELL.

GENTLEMEN,—No new method of treatment, with the possible exception of Koch's tuberculin, has caused such a sensation as that of Radium. Probably if the Registrar General's reports were consulted it would be found that the mortality of cancer has been as little affected by radium as the mortality of tuberculous diseases was affected by tuberculin. It would, however, be inaccurate to say that the discovery of radium was not an important factor in the treatment of malignant disease. I propose to deal to-day with the physical properties of radium and also with its effects as a therapeutic agent.

The discovery of radium was in a large measure due to the discovery of X-rays. These are formed by cathode rays being stopped by the glass of an X-ray tube, and at the parts from which they are emitted fluorescence of the glass is observed. This gave rise to the suggestion that fluorescence might in some way be connected with the formation of rays, and therefore that phosphorescent substances might also give off rays. Becquerel experimented with fluorescent salts of uranium and obtained photographic impressions by placing uranium salts, which had been exposed to the light, on photographic plates wrapped in black paper. On further investigation he found that previous exposure to light was unnecessary in producing the impressions, and that all uranium salts produced this effect whether fluorescent or not. This led to the discovery of what is now known as radio-activity, and was followed a few years later by the discovery by Mme. Curie of a more active substance than uranium, viz., radium.

Becquerel's experience was the first to direct the attention of the medical profession to its therapeutic use. Having inadvertently kept a tube of pure radium for several hours in his waistcoat pocket, he was surprised a fortnight later to find a severe burn on his abdomen.

Dr. Danlos, who saw the burn, was then given some to work with and found it a useful substance medicinally.

Radium as a metal has only been isolated recently and is a white metal, but as the bromide it is a brownish crystalline solid. It possesses the property of giving off a stream of particles which travel almost with the velocity of light. These particles are so light that the weight of radium scarcely diminishes in a thousand years. When its rays strike certain bodies they fluoresce, and an electroscope is discharged by them. Its temperature is three degrees F. above that of the atmosphere, and it has the property of making diamonds glow in the dark, thus distinguishing them from paste.

Radium exists in all uranium ores, of which the most important is pitch-blende, from which almost all the available radium has been prepared, but it also exists in carnatite and thoria-nite. Pyromorphite is a substance consisting chiefly of lead phosphate, which contains radium without uranium. In extracting the radium the ore is crushed, chemically treated and washed, and finally separated from the barium salts by fructionisation, one ton of ore giving rise to 2 to 500 mgms. pure radium bromide. Radium is two million times as radio-active as uranium, and its quantity is measured by comparing the time a given sample takes to discharge an electroscope with that taken by a known quantity. In this way it is so much easier to arrive at an accurate knowledge of the amount present than any other method. It gives off three different kinds of rays which, though invisible, produce certain definite effects. The X-rays are particles of the size of an atom of hydrogen, the same nature as the anode rays of a Crook's tube, and travel with one-tenth of the velocity of light. They form 90 per cent. of the radiation given off by radium and can penetrate a very thin layer of metal. The B-rays are about 500 times as penetrating as this, they are similar to cathode rays, and are charged with negative electricity. They form 9 per cent. of the total radiation. The B-radiation is formed of a large number of rays, some scarcely more penetrating than the F-rays, and some almost as penetrating as the G-rays. These G-rays form 1 per cent. of the whole; they are similar in nature to X-rays, but are enormously more penetrating, and throw scarcely any shadow of the body on an X-ray screen. For this reason radium is useless for radiography. On the other hand, it produces a much deeper effect on tumours than X-rays.

Radium being a heavy substance when pure, an amount of even 5 mgs. is not bigger than a grain of barley. It was used at first spread over a flat metal plate, and fixed on it with a varnish. In this way of course it is very suitable for treating superficial conditions like rodent ulcers, and nævi of different kinds. Later, by placing the radium in a small tube a more powerful action was obtained, and the insertion of a tube within a cancerous tumour forms the present

day method of dealing with these growths. By this method *all* the radiations are made use of, whereas in the former method of applying a plate or "Applicator" to the skin only half the radiations were employed. Radium is sometimes applied without any protection at all to the surface of the skin, and it is possible to cure a rodent ulcer in this way without producing any inflammation of the skin. It is, however, much quicker to give an application long enough to produce some redness which lasts two or three days. As the whole of the rays are used the application must be a short one, in the case of the flat applicators half-an-hour or less. In the case of nævi I think it is essential to produce some inflammation before any good result can be obtained. In treating malignant tumours a different method has to be adopted, as the action of the radium must not be expended on the skin which may be perfectly sound, but must penetrate the skin doing it as little damage as possible, and act on the cells of the growth, below which are young growing cells, and particularly susceptible to the action of radium. The radium, therefore, is put in a tube, or in the case of a flat plate covered with a piece of lead 1 mm. thick which cuts off the X-rays and almost all the B-rays. As only a small percentage of rays can penetrate the lead the application must be a very long one, and may be any time up to 100 hours or more, varying, of course, with the amount of radium, and the tumour. The G-rays passing through lead form what are called "secondary radiations," and these produce an inflammatory reaction of the skin. This, although only transitory, can be avoided by interposing twenty or thirty layers of paper and three or four of lint. If radium is buried in a tumour it is not always possible to put on these coverings, but it is wiser to do so if possible.

Whatever opinion is held about radium in the treatment of cancer, there can be no doubt whatever about its effect on the symptoms in a favourable case. As showing this, A. B., æt. 76, complained of a lump in the inner and upper quadrant of the left breast. It had been present two years, and the pain in the lump in the left arm and back were so bad that she felt compelled to see a doctor which she had not liked to do before. On examination there was a large ulcerated lump fixed to the chest wall with stabbing pain in it which kept her awake at night. There were enlarged glands in the left axilla and numbness in the third and fourth fingers of the left hand. The lower thoracic vertebræ were tender on pressure, and the pain radiated round to the front of the abdomen. There was exophthalmos of the right eye; 11½ mgs. of radium were applied to the breast, axilla, and back, and after a fortnight's treatment the pain had completely gone. Two months later the pain began to return and was again relieved by radium in the same way. In another case the patient had had her uterus removed for cancer a year previous to being seen. There was then a profuse watery blood stained offensive discharge, pain in the back, and a large fungating mass locally. Three or four applications of half-an-hour without any covering over the radium (22 mgs.), except gutta percha tissue, were sufficient to relieve the pain and discharge completely. A few weeks later the pain and discharge returned and the applications she had had before failed to relieve the symptoms. Two applications of forty-eight hours each were then given, the radium being protected with 1 mg. thickness of lead, and the symptoms were then relieved for three months, the fungating mass becoming distinctly smaller.

The relief of symptoms which I have here described is of little importance compared with what radium may do in cases where, while an operation is impossible, an apparent cure may sometimes be produced. A patient presented herself for radium treatment who nine months previously had had her breast removed by a London surgeon. There was a swollen mass above the clavicle which was tender to touch, and two or three flat nodules in the course of the scar. About 300 hours of radium treatment with 1 mm. lead protection were given; now, eighteen months later, the patient is alive and well.

Two patients had had operations for carcinoma mammæ, and three months later developed bad painful swellings about two inches below the clavicle. Radium was applied to each, and now, 21 months later, these patients are quite well.

Two years ago a patient, who had had a similar operation, came for a large swelling in the middle of the sternum and one in the axilla. There was pain and shortness of breath. These cleared up with radium, and the patient is now apparently well.

These may be taken as favourable cases who have been apparently cured where surgery alone would, in all probability, have failed. It is, however, impossible to say that these cases are less likely to recur than any others which have had a similar operation. It is far commoner

to find cases in which a slight, but definite, improvement is obtained, but subsequently the patient goes down hill.

A patient illustrating this was treated with radium for $2\frac{1}{2}$ years for a swollen arm and lump involving the clavicle and spreading above and below it. This was fixed to the skin, which was reddened over it. After a few applications of radium the swelling of the clavicle diminished considerably, and the skin over it became loose and regained its normal appearance. The swelling in the arm went down very much. Though there was little change in these two parts for about a year, the patient died of secondary deposits in other places. This swelling of the arm is one of the commonest signs of recurrence of carcinoma mammæ. The fore-arm swells first, then the upper arm, and then the hand. If radium is applied to the enlarged glands in the axilla, the swelling diminishes first in the hand, then in the upper arm, and lastly in the fore-arm. The swelling of the arm is reduced long before the axillary glands show any sign of reduction, but unless the swelling has been slight the skin of the fore-arm almost always appears to have been permanently stretched.

Unfortunately radium is very far from curing all cases of cancer, and fails from one of two reasons. Either fresh neoplasms arise in other places or else the radium fails to cure the primary source. The first cause can scarcely be prevented, as it is an inherent property of cancer. The second, however, deserves consideration. In the first place, radium, even in the most favourable circumstances may fail, and it is impossible to tell a favourable case with any certainty. On the other hand, it may succeed in the most hopeless. Between these two extremes lies the vast majority of cases in which success seems probable, but ultimately the patient dies. As an example, one may take a patient who, after an operation for growth, develops a large mass of glands above the clavicles. Radium is applied, and within a few hours the stabbing ceases, later on the dull ache goes, the ulcerated surface, if present, heals over, and in three weeks' time the mass is less than half its original size. These may, indeed, entirely disappear, but will possibly recur later. The whole course of treatment is then less satisfactory, but the mass of glands may again go. If they recur a second time it may be found that the application of radium will actually bring on the pain so that the patient may say that he cannot stand it. When this happens I think it wise to leave off the application. In this case it is possible that a smaller amount of radium would relieve the pain, but it is very unlikely that it will get rid of the lump, and it may make it grow faster. Whether radium can actually increase the rate of growth of cancer I do not know, but there is no doubt that there are competent observers who say they have seen cases in which it appears to have done so, and I always stop using it before any suspicion of such a thing may arise. A case showing this was a lady patient with a growth of the rectum on the anterior wall, so that it could be treated by using radium in the vagina. After two or three applications of forty-eight hours at intervals of a month the bearing-down pain ceased, then the bleeding and discharge stopped, and the ulcer seemed less deep and smaller in diameter. After a few months, though the same treatment was continued, the discharge and other symptoms began to return, and the treatment was stopped, the patient subsequently having a colotomy done, and dying later. In this case it would probably have been better, if it had been possible, to have given one longer application to start with.

The question of the quantity of radium to be used is a very difficult and complicated one, and probably varies with each individual case. In one patient I had, 22 mgms. applied to a growth of the rectum actually increased the pain, while 2 mgms. relieved pain, discharge, and bleeding almost at once. This, however, is very exceptional, and, as a rule, the larger the quantity of radium the better the effect. That the amount of radium is not the only factor in curing cancer may be gathered from the report in the daily papers of a man who had 1,000 mgms. buried in a growth which a few weeks afterwards killed the patient. Another patient had an even larger amount than this used for a growth. This patient went down hill rapidly, and it is open to question whether the larger amounts used in these two cases did not actually hasten the end. Professor Berm has published his opinion that the use of 500 mgms. is dangerous to life and that 300 mgms. in five or six hours will produce fever. In his opinion 50 mgms. is about the best amount to use. In the cases described here the maximum amount used was $22\frac{1}{2}$ mgms. which were spread over a metal plate 3 cms. square. The largest amount I have ever used

was about 120 mgms., but this was in two or three different pieces, and the radium was spread over flat surfaces. This was used to treat a carcinoma mammæ which would have been considered operable if it had not been secondary to a growth on the other side. The growth diminished in size, but never disappeared, and after a few months began to grow, and the radium seemed to have no effect whatever in stopping its progress. The action of 20 mgms. radium spread over a flat surface is far less powerful than if kept in a small tube, and the most satisfactory results will probably be obtained from burying a tube in the middle of a growth.

The cases of cancer in which radium is most likely to be of use are those of carcinoma mammæ. The early secondary deposits in this disease are almost always superficial, and there is always some chance that if these are treated before they become large that secondary deposits in the deep structures may be warded off indefinitely. Enlarged glands in the neck and axilla and nodules in the skin, ribs, and sternum may all be treated with some prospect of success. Probably growth of the cervix might be treated with great advantage in selected cases. In cases of cancer in other situations radium at the present time has less chance of being useful. There is always more doubt about the success of radium than that of surgery, and, therefore, it is never justifiable not to operate if it is possible. If it is impossible, in most cases the reasons which prevent an operation will prevent radium doing good.

Dispensary and Pharmaceutical Laboratory Report for 1913.

The total number of Out-Patient attendances at the Dispensary during 1913 was 188,238, as compared with 197,557 in 1912, 220,591 in 1911, 221,847 in 1910, 203,445 in 1909, and 198,332 in 1908.

These are classified for the last two years as follows:—

NUMBER OF DISPENSARY ATTENDANCES.

1913.	Medical.	Surgical.	Casual.	Total.
Paying ...	66,304	36,449	40,682	143,435
Free ...	13,444	7,309	24,050	44,803
Total ...	79,748	43,758	64,732	188,238
1912.				
Paying ...	70,622	35,581	42,207	148,410
Free ...	13,831	7,799	27,517	49,147
Total ...	84,453	43,380	69,724	197,557

The receipts have been as follows:—

	1913. £ s. d.	1912. £ s. d.
Out-Patients	1,784 18 5	1,841 12 3
Sale of Drugs	210 3 4	173 16 11
Net Profit on Sale of Bottles to Out-Patients	80 0 4	75 5 6
Goods supplied to the Medical School... ...	121 8 0	73 4 5
Goods supplied to the Dental School	80 17 10	81 5 0
Goods supplied to the Institution	14 10 1	17 7 0
Total	£2,291 18 0	£2,262 11 1

THE NATIONAL INSURANCE ACT.

During the last year the chief factor influencing the number of Out-Patients has been the National Insurance Act, which, so far as Medical Benefit was concerned, came into operation in January last. The effect on the Dispensary attendances for that month was not very marked, but both February and March showed a decrease in number of attendances of about 2,000 over the previous year. In April, however, the returns had again risen to their normal level, but subsequent months showed a uniform decrease of about 500 per month compared with 1912.

By transferring dispensing from Medical Practitioners to Pharmacists the Act has been the cause of a general shortage in the supply of qualified assistants. In consequence salaries have advanced by 20–40 per cent.

On the other hand the Hospital now receives payment for drugs and dressings supplied to members of the Nursing Staff, amounting to £80–£100 per year.

The increase in the amount of chemicals bought by the Medical School is due to the fact that during the past year it has been decided to co-operate with the Hospital in buying a certain number of commonly used chemicals hitherto bought independently. These will in future be obtained through the Dispensary in order that both the Hospital and the Medical School may obtain the mutual advantages of the cheaper rates available for larger quantities.

Chemicals have been supplied to the various departments to the value stated below.

	1913. £ s. d.	1912. £ s. d.
Surgical Skiagraphic Dept. ...	10 5 2	14 5 7
Medical Skiagraphic Dept. ...	41 7 11	48 18 7
Works Department	10 2 7	12 14 2
Orthopædic Workshop	11 1 4	—
Total	72 17 0	75 18 4

The approximate cost of Drugs and Dressings during the last two years is given below.

	1913. £ s. d.	1912. £ s. d.
Drugs	3,300 0 0	3,520 0 0
Dressings	3,000 0 0	3,070 0 0
Total	6,300 0 0	6,590 0 0

ANÆSTHETICS.

	Quantity used.		Cost.	
	1913.	1912.	1913. £ s. d.	1912. £ s. d.
Absolute Alcohol	76 lbs.	95 lbs.	14 18 8	19 11 1
Chloroform	1,057 lbs.	864 lbs.	72 5 0	59 2 2
Cocaine and its Salts	16 ozs.	17 ozs.	7 16 8	9 10 3
Ether	1,792 lbs.	1,238 lbs.	82 2 8	118 8 11
Ethyl Chloride	11 doz.	24 doz.	9 9 6	20 5 0
Eucaine Lactate	5 ozs.	4 ozs.	2 2 9	1 12 4
Nitrous Oxide	40,600 gals.	38,100 gals.	64 16 6	64 6 3
Novocaine	—	—	11 6 4	7 8 2
Stovaine	10 grammes	—	0 3 6	0 1 8
		Total	£265 1 7	£300 5 10

This table reflects certain changes which have been made during the last few years. In 1910, Absolute Alcohol, costing £74, was used. This large decrease is due to the decline in the use of A.C.E. Mixture, and to the replacement by duty-free Alcohol, costing about one-tenth the price, for sterilising purposes. Both Ether and Chloroform have increased in consumption, the former by nearly 50 and the latter 25 per cent.

The Ether now used was chosen on account of its freedom from impurities, as the result of the examination of the products of most of the largest manufacturers. In addition to the Ether used for anæsthesia, 11 cwt., costing £43, have been used, largely in the manufacture of Ether Soap, of which 278 gals. have been made.

ANTISEPTICS.

	Quantity used.		Cost.	
	1913.	1912.	1913. £ s. d.	1912. £ s. d.
Acid, Boric	29 cwt.	28 cwt.	38 8 6	35 16 0
Acid, Carbolic	29 cwt.	29 cwt.	84 7 0	108 1 0
Chinosol	14 lbs.	10 lbs.	5 14 7	5 4 2
Cresol	566½ gals.	245 gals.	45 10 4	28 11 2
Formaldehyde	1120 lbs.	686 lbs.	21 14 10	13 15 0
Hydrogen Peroxide (20 vols.)	772½ gals.	688 gals.	70 6 3	64 11 8
Iodoform	7 lbs.	42 lbs.	4 15 8	24 6 6
Lysol	445 gals.	949 gals.	71 6 2	168 3 6
Mercuric Chloride	74 lbs.	56 lbs.	8 7 9	6 19 5
Do. Tablets	20 lbs.	12 lbs.	1 13 4	1 0 0
Mercuric Iodide	31 lbs.	6 lbs.	3 6 5	3 1 10
		Total	£355 10 10	£459 10 3

SERA.

	Quantity used.		Cost.	
	1913.	1912.	1913. £ s. d.	1912. £ s. d.
Anti-Anthrax Serum	410 ccs.	none used.	6 16 8	—
„ Colon Bacillus	120 „	360 ccs.	2 19 3	4 7 6
„ Diphtheria	2200 „	2000 „	54 11 2	50 2 0
„ Meningococcus	180 „	130 „	4 10 6	1 18 3
„ Pneumococcus	20 „	110 „	0 6 10	1 19 6
„ Streptococcus	2950 „	3960 „	17 14 3	29 12 3
„ Tetanus	680 „	720 „	13 4 0	7 12 0
„ Thyreodin	30 „	360 „	0 11 0	6 4 1
Normal Horse	630 „	780 „	2 16 3	3 5 11
		Total	£103 9 11	£ 105 16

DRESSINGS.

	Quantity used. 1913.	1912.	Cost. 1913. £ s. d.	1912. £ s. d.
Bandages, Crepe	42 doz.	24 doz.	12 12 0	7 16 0
Bandages, Grey	1,021 gross	1,128 gross	496 9 2	523 6 8
Bandages, White	686 gross	776 gross	444 4 10	501 6 10
Bandage Cloth	27,846 yards	19,884 yards	184 18 10	130 12 8
Cellulose Wadding	56 lbs.	2 cwt.	0 18 8	5 14 8
Felt	27 lbs.	17 lbs.	8 1 7	5 1 2
Felt, Poroplastic	9 lbs.	9½ lbs.	2 0 3	2 2 9
Gauze, Double Cyanide	45,600 yards	44,412 yards	129 0 0	122 15 9
Gauze, Grey	36,432 yards	38,964 yards	91 18 0	92 11 6
Gauze, Iodoform	9,204 yards	6,804 yards	35 8 7	24 1 11
Gauze, Ribbon	85 doz.	28½ doz	26 2 9	9 11 9
Holland, Brown	28 rolls	—	54 0 5	—
Lint	123 cwt.	120¼ cwt.	692 17 8	677 12 0
Lint, Boric	31½ cwt.	38 cwt.	133 8 8	165 4 0
Moss, Compressed	100 sheets	91½ lbs.	3 9 3	4 11 6
Strapping, Rubber	49 doz.	43 doz.	54 6 6	47 11 7
Tissue, Wool and Gauze	7 cwt.	5 cwt.	28 13 0	20 9 6
Tissue, Gutta Percha	540 lbs.	542½ lbs.	94 19 5	94 18 10
Tow	6 cwt.	10 cwt.	7 8 0	12 10 0
Tow, Carbolised	—	63 lbs.	—	1 6 10
Wool, Absorbent	120 cwt.	88 cwt.	348 16 8	404 11 0
Wool, Grey	39 cwt.	33 cwt.	75 1 6	63 19 10
Total			£2,924 15 9	£2,917 16 9

The following figures are given to show the large amount spent on certain principal items:—

	Quantity used. 1913.	1912.	Cost. 1913. £ s. d.	1912. £ s. d.
Bismuth Salts	277 lbs.	393 lbs.	119 5 6	161 18 1
Camphor	418 lbs.	453 lbs.	33 6 10	36 16 3
Cod Liver Oil	375 gals.	250 gals.	64 13 9	44 18 4
Glycerine	32 cwt.	34 cwt.	146 10 0	156 7 0
Honey	25½ cwt.	23 cwt.	39 1 10	32 8 3
Lard	10¾ cwt.	16 cwt.	30 14 5	42 14 0
Malt Extract	160 cwt.	160 cwt.	168 0 0	168 0 0
Olive Oil	222½ gals.	243 gals.	64 6 9	59 3 3
Oxygen			89 13 5	100 13 7
Potassium Iodide	235 lbs.	336 lbs.	116 15 2	133 15 2
Spirit, Methylated	1,600 gals.	1,760 gals.	178 4 8	184 13 4
Spirit, Rectified	100 gals.	150 gals.	131 5 0	195 4 2
Sugar	84 cwt.	75 cwt.	75 15 11	75 15 0
Total			£1,257 13 3	£1,392 6 5

PHARMACEUTICAL LABORATORY.

The work of this section has included the following:—

	1913.	1912.
Collodions	4½ gals.	6 gals.
Confections	2 cwt.	5⅔ cwt.
Dentifrices	1½ cwt.	1½ cwt.
Lotions	5,000 gals.	5,060 gals.
Liniments	226 gals.	290 gals.
Mixtures	8,782 gals.	11,150 gals.
Ointments	54 cwt.	47½ cwt.
Plasters	3,840 yds.	4,505 yds.
Syrups	841 gals.	950 gals.
Tablets (Compressed)	11½ cwt.	18 cwt.
Tinctures and Liquid Extracts	257 gals.	245 gals.
Soda Water	22,395 syphons	32,332 syphons
Ether Soap	278 gals.	264 gals.

Among the articles requiring special mention are the following: -

Liquid Paraffin.—68 cwt., costing £127, were used in 1913, compared with 40 cwt., at £73, in 1912. While most of this is administered alone, some of it is given in the form of an emulsion. In this way it has been responsible for an increase of £19 in the amount spent on acacia gum in the last year.

Salvarsan and Neo-Salvarsan.—320 tubes have been used at a cost of £95, against 200 tubes, costing £70, in the previous year.

Pituitary Extract.—The cost of this has decreased from £59 to £34.

The consumption of rectified spirit has decreased to 100 gals. It is of interest to note that in 1901 the amount used was about 500 gallons, the extra amount being mostly used in the preparation of stock mixtures of the Hospital Pharmacopœia. With the concurrence of the Medical Committee, certain of these mixtures are now made with concentrated tincture, *i.e.*, those containing a larger proportion of drug to alcohol. To give a simple example: The ingredients for eight gallons of compound tincture of camphor are dissolved in one gallon, and when making a stock of Mist. Oxymellis Co., instead of using eight gallons, one gallon of the concentrated tincture is used.

SUPPLIES AND TENDERING.

It may be of interest to give an account of the system by which supplies are bought, together with a recent development of the same, and some suggestions for the future.

A Tender Form containing a list of about two hundred articles in regular demand is advertised in March, and is issued freely to all applicants.

These articles may be divided into two classes:—chemicals for which a standard is specified in the British Pharmacopœia, and for which the lowest price is usually accepted. The second class includes the crude drugs for which no exact standard is possible. These are bought from sample, good quality being the first consideration and price the second.

Some of these crude drugs, such as buchu and senna leaves, senega root, etc., are judged with respect to their general appearance, such as the presence or absence of signs of careful harvesting.

There is a third class of articles which it is advisable should not be included in the Tender Forms. This contains such substances as the volatile oils, and belladonna root, which can only be judged after chemical examination.

Supposing six firms are tendering, and each sends a sample of all the volatile oils required. Two objections apply: the sample is usually insufficient for a thorough examination, and there are more samples than can possibly be tested in the limited time available, since the whole tender must be accepted or rejected within, say, a week.

A better system has been adopted during the past year. The firms from whom the supplies are obtained are selected with reference to the chemicals and drugs of stable quality, and when the stock of such an article as oil of lemon is falling low these firms are requested to submit samples, of a specified size, to be paid for and large enough for examination. In this way the sample of oil of lemon which would have been chosen was proved to contain nearly 20 per cent. of alcohol, costing about one fifth the price.

While the contract system is undoubtedly an efficient one for articles of a definite standard quality, it is open to the objection that in the absence of this it always works in the direction of the lowering of quality. Supposing a firm tenders, and intends to supply an article of good quality, but finds the tender declined on the question of cost. The tendency is to quote next year for an inferior article. Should their tender still be too high, the quality is again reduced until the minimun is reached.

An illustration of this has occurred in the case of calamine. This is a naturally occurring impure carbonate of zinc, with which is associated in varying proportions barium sulphate. There is no official standard for it, and the quality has gradually suffered until at the present time Calamine consists almost entirely of coloured barium sulphate.

During the past year representations were made from what is practically a ring of the wholesale drug trade, that the tenders issued by the hospital were in one respect unfair to the contractors, in that no definite quantities were stated.

Hitherto it has been the custom to give in these Tender Forms, as a guide, the quantities actually bought in the previous year. Whilst this is adequate in the majority of cases, it would appear to be insufficient for some articles, the trade in which is subject to severe competition, and such an approximation, if adopted by all hospitals, was said to make it difficult for the firms tendering to compute their own annual requirements. Moreover, this system rendered it possible for the accusation to be made, as was actually done, that a certain hospital bought as little as possible when the price was falling, but that its stocks were unduly increased, at the expiration of a contract, if prices were rising.

These facts being considered, the House-Committee decided that in future Tender Forms should specify definite quantities, and, if the requirements shall exceed these amounts, that fresh quotations shall be made. Only experience can show how much this change will increase the amount of work involved, but it is certainly in the interest of fair dealing.

H. FINNEMORE, B.Sc., F.I.C.,
January 28th, 1914. Pharmacist to the Hospital.

Papers Received.—Nursing Times, Hospital, Polyclinic, Magazine of London (Royal Free Hospital) School of Medicine for Women, St. Bartholomew's Hospital Journal, St. George's Hospital Gazette, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette, Prescriber, Clinical Journal, New York State Journal of Medicine.

The Extraction of Needles.

By J. GODFREY SANER, M.C.

The difficulty found in the removal of foreign bodies is proverbial. Needles, at the present time, being the Resident Surgical Officer's perquisite, I submit the following method as helpful. It has been successful in all except one case, over a period of four months, during which some forty cases have been operated on. In cases where the needle can be felt under the skin, it is not necessary. In the failure, the needle was embedded deep in the upper part of the calf, and, after a short attempt, the case was taken into the wards. A more extensive dissection, under a general anæsthetic, was ineffectual.

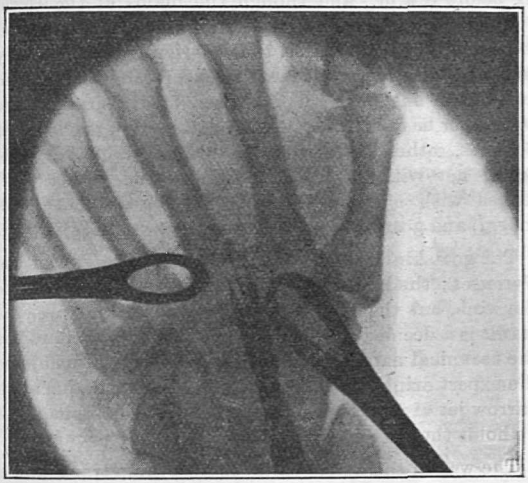

Fig. I.

If a needle is deeply placed, and causing no symptoms, patients are advised against operation as it seldom causes trouble later. However, many insist on an attempt at removal being made at once. This method is rapid and little, if any, damage is done to important structures.

The position of the needle is marked on the surface by the Radiographer and its approximate depth estimated. The part is then well swabbed over with iodine and placed on a sterile towel on the X-ray couch. A local anæsthetic of ·25 per cent. novocain is used freely in the area to be explored. To increase the rapidity of action of this drug a few minims of adrenalin solution are added to the initial injections. The presence of a quantity of fluid alters the depth of the needle to a considerable extent. This has to be taken into account in the later manipulations.

The operator having satisfied himself of the anæsthesia, a second towel is placed over the hand exposing the marked surface through a central hole. The screen used by the Radiographer is also encased in a sterile towel as it frequently comes in contact with the instruments. An incision is then made through skin and fascia. This incision is planned with the object of avoiding any structures of importance in the further dissection and is generally in the long axis of the limb. Tissue forceps are fixed to the edges and the wound held well open. The weight of the forceps is generally sufficient for this purpose. A fine pair of artery forceps, of the "mosquito" pattern, with the blades closed, are laid in the wound and the rays turned on. The point is then gradually worked through the tissues in the direction of the foreign body. This should be done with the forceps in the vertical plane, *i.e.*, parallel to the rays from the tube. This is most important.

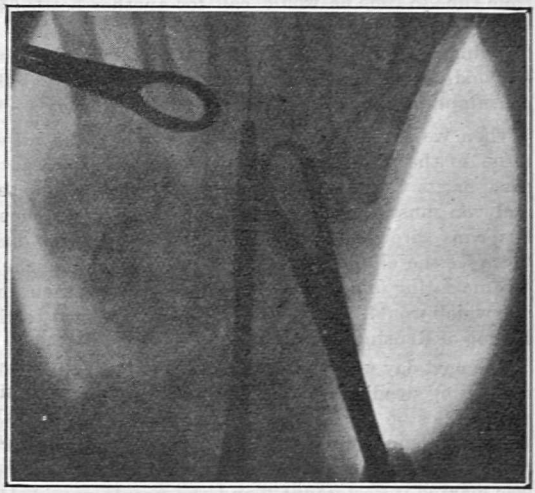

Fig. II.

Having reached the needle the blades are opened and the needle grasped, if possible, towards one end. The rays are then turned off. At this stage, by depressing the handle of the forceps the needle is often brought directly to the surface without further dissection. If this is not possible, a little blunt dissection exposes one end, which is grasped by a second pair of forceps, and the needle pulled out forthwith. The grasping forceps should not be relaxed until a full view of one end of the needle has been obtained and a second pair put on.

Thanks are due to Mr. H. N. Eccles for his patience and help during these operations, and also for the photographs which explain themselves. He states that the exposure is so short that there is no fear of an X-ray burn.

Through Andorra.

I.

If you have come across France by the Rhone Valley it is a difficult matter to get to Ax-les-Thermes; for Ax is on the Toulouse railway, and to travel via Toulouse means a long journey with many changes.

I, having reached Carcassonne, was anxious to get to Ax; there is no way into Andorra save by Ax. So to shorten our train journey we went by a little loop-train which winds into the mountains from Carcassonne, and at noon we got out at the little town of Quillan.

Of Quillan I know nothing except the waistcoat of the Inn proprietor; this is of a fancy check pattern, and its owner is given to saying, in a very hearty voice, "In the Midi we drink much wine!" And indeed the wine is very good there; the proprietor sat opposite us as we ate our lunch, we told him our plans and showed our maps; from time to time he would call for another bottle; he was a restful man, making few movements save those of drinking and pouring out; he drank water with his wine to avoid, he explained, the drunkenness that follows the consumption of undiluted wine in midsummer.

Then we set out on foot for Ax, and at night-fall we came to the village of Espezel, which is as pleasant a place as its Catalan name would lead you to suppose; and you must not condemn it merely because a motor bus runs through it once a day, for at dusk you may there see the children playing at "La Poule Blanche," a game daring in design but innocent in execution, but one which would, I am afraid, give great offence to the Bishop of Kensington.

The next day we went on through shallow valleys, the road rising steadily, between vineyards where the people would all stop work to ask us where we were going; then rain came, and with it hunger, so that we were obliged to stop at a cottage in a tiny village; the cottage was marked "Resteraunt," and the people provided us with rugs and dried our clothes in front of an open fire; a big cauldron hung over the fire and beside it sat an old woman who rocked herself backwards and forwards, she did not speak but her son explained that she had a touch of toothache.

Having said that they were but poor folk, and unable to give us much, they prepared a light lunch of hors d'œuvres, omelette, steak, vegetables, salad, cheese, and wine, with which we had to be content; afterwards we struggled on through the mist.

The road ran up more steeply, and we came to the top of a small pass; it was very misty at this time and it was not until we had descended for some two miles that we were able to see the valley. Then we came into bright sunshine, and below us we could see Ax-les-Thermes.

Wherever the beautiful water of the Pyrenees becomes polluted by iron-ore or by sulphur, and wherever its coolness is lost by contact with some hot underground stratum, there will the French people set up an établissement thermale, and thither will the bourgeoise flock.

Ax is a very beautiful spot lying at the junction of the Ariege and Oriege, twin tributaries of the Garonne; but it is now conspicuous by three sets of public baths and a Kursaal, two big hotels, motors, pretentious monuments, and a bad town band. Nevertheless, if one is there out of the "season," it is a good little town; it is there that the people of the mountains come to market; the washerwomen sing at their work outside the Cripple's Hospital, and at night strolling minstrels play popular tunes on wine bottles.

* * * * *

To reach Andorra from the north, one must ascend the Asten Valley, which joins the Ariege Valley at some distance from Ax at a station called Les Cabanes; and here a difficulty meets the traveller. For the train leaves Ax before 8 a.m., and though the maids at the Hôtel Sigre are as honest as the day, and sufficiently beautiful to have been born at Arles, the proprietors are three very ancient ladies, very withered in heart and conscience, and unless one's account has been paid overnight, one will either be cheated or lose the train. We reached Les Cabanes, rather vexed with the old ladies of the Hôtel Sigre, hot with catching the train, and rather overloaded with blankets, cooking-pots, bread, chocolate, maggi, and goatskins full of wine.

The goatskin bottle is found from end to end of the Pyrenees; the hair of the goat is said to add richness to the wine, but the tarry substance which is put over the seams is a decided drawback. These bottles ("Bota" is the technical name) have a minute stopper in them, and the expert drinks by removing this and squeezing out a narrow jet of wine, which rushes down his œsophagus as he holds the bota above his head.

The way of the Asten Valley is by a mule track, and a Pyrenean mule-track is a thing difficult to describe; it is made mostly of large boulders, many of them the size of a man's body; at times, when there is a little grass between the mountain side and the stream, the track will disappear for half a mile, then will come more rocks. The ascent is very steep; the Asten comes tumbling down a series of cascades, and the valley winds in and out, but always the mule-track ascends steeply. At first we could turn round and see the pink limestone cliff of the Ariege Valley behind us, but after a few miles the Asten Valley closed in, and we seemed to climb up and up a steep stone stairway between narrow walls of forest.

At noon we lit a fire and made a soup; why is it that in England one cannot buy Maggi? Surely the landladies of Honor Oak Park would not mind preparing one of the fifty different soups you can make from that inexpensive substance; in twenty minutes a man can cook for himself a very pleasant dish which, even if of

no nutritive value, is an excellent way of helping one to get down a large quantity of bread.

After lunch we went on and up; then came rain, a combination of thick Scotch mist and heavy downpour. "The Asten Valley," says Mr. Belloc, "contains the best camping-grounds in the Pyrenees; even where the forest is not abundant there are many over-hanging rocks to give excellent shelter." The only over-hanging rocks I saw were embedded in little lakes; the sheltering woods were so wet that I could see little prospect of getting a fire alight, even if I were to soak twigs in methylated spirit.

For an hour we lay among the roots of a beech tree until we were so cold and wet that walking became preferable; a council was held, and it was decided that death was preferable to turning back.

So we went miserably on and at half-past three, when the necessity of camping was becoming urgent, we came out on to a green "jasse" where little tributaries running down to the Asten had left a broad piece of meadow land; here we found two huts, and saw men and dogs. These were two cowherds, who live all the summer up in the mountain with their cattle; the head man, a charming but gloomy Catalan, begged us to use one of the huts; he then glared across the valley and kept groaning out "quel pays! quel pays!" "After all God made it," said my friend; "There is no God here, sir," said the Catalan, and gave us a lecture on the folly of entering the mountains.

Conscious of his own dialect, he asked if we were Frenchmen, but was not surprised to hear that we were English; he had seen those before, there had been two in the valley in the previous summer, and there was a mad Englishman who, with his wife, used to camp at the Lake of Feuntargente, on the high pass, to fish for trout and shoot the mountain sheep; he was reputed to be in Andorra this year.

We went over to the wood and chopped wood, carrying branches as big as we could lift back to our hut. This was a small place with thick stone walls and a heavy thatched roof; one end was one huge open fire place, and the floor was raised a foot above the ground and fire, and was lined with straw and twigs, the doorway was a sort of chink, about two feet wide; there was dry wood inside and we soon had a good fire going.

Then a party of men with mules arrived bringing food for the cowherds; it was the "patron" come to inspect his stock; soon the whole valley was echoing with the cowbells, and all that night the jasse was filled with the great grey cattle. The new arrivals had taxed the local accommodation, and one of the cowherds, with his little boy, came over to sleep in our hut. We had been rather proud of our wood-supply, but the peasant only grunted when he saw it, and going out he came back with a tree-trunk a foot thick and six feet long; this he put on the fire, and through the night I often acknowledged his wisdom.

His hatred of the mountain was as great as that of his fellow, and he told many melancholy stories of men lost in those parts; he also told us how he and his friend would walk for nine hours to Andorra and back in order to smuggle tobacco which is a full halfpenny an ounce cheaper in that blessed land.

At last, with a graceful gesture, he handed round his wine-flask, hung his socks up on the roof-beam, kissed his son, and curled up to sleep. His son, having dealt likewise with his socks, appeared to tell his father a long fairy-story in Catalan, but at the end of ten minutes was silenced by a grunt. He then went to sleep.

(To be continued.)

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Pocket Guide Series. (London: Scientific Press, Ltd.) Price 1s. net each volume.

The Nurses' Duties Before and During Operations. By Miss E. Margaret Fox. Miss Fox is to be congratulated on a very excellent little résumé of the duties of a nurse before and during an operation. She has wisely avoided the obvious pitfall in not trying to condense too much detail into a very small space. This volume should be of great service to theatre probationers and nurses doing private work. It has also the additional advantage of being written by an old Guy's nurse.

Asepsis and How to Secure It. By H. W. Carson, F.R.C.S. This, the latest volume of the S. P. Pocket Guide Series, in which so many useful little booklets have appeared, is well up to the average of its predecessors. It is well and lucidly written, and contains all the essential facts about the details of asepsis.

The Administrative Control of Smallpox. Wanklyn. (London: Longmans, Green & Co.) Price 3s. 6d. net.

This book will be found extremely useful for all those who may have to deal with an outbreak of smallpox, and it is therefore primarily written for those who intend to take up the duties of a medical officer of health. A case of smallpox is reported to you, what are you going to do? The disease, like an outbreak of fire, must be instantly met, and the method must be complete in every detail. This responsibility rests entirely on the medical officer of health and his staff of assistants, and unless they are forearmed, unless they know beforehand exactly what to do and how to do it, the focus of infection, like fire in a closely populated area, will quickly spread and the conflagration will pass beyond control. Experience is the best teacher—we learn by our mistakes—but in a matter

of such vital importance to the community as this, the fact that a medical officer has never had occasion to deal with such an emergency can never serve as an excuse for his deficient handling of the situation. A text-book may tabulate rules, but rules without adequate illustrations are not readily assimilated. To get a man who knows what he is talking about to give you his actual experience is, next to actual practice, the most effective way of learning. And this is just where this little book succeeds. It is written in such a way that the author himself might be speaking to you, thus it is very easily read, and the knowledge it imparts is such that every man who may have to deal with an outbreak of smallpox, and who has not had actual experience, will do well to read it and keep it by him.

Disorders of Children. By John McCaw, M.D. (London: Baillière, Tindall & Cox.) Price 10s. 6d. net.

The author desires to set before us a book of moderate dimensions, and of modest price. Were the contents on the same scale, a valuable work would have been produced. But for a book of only 500 pages to attempt to include so many of the rarer disorders of children, is to sacrifice room which might have been given to fuller accounts of the commoner ailments. This lack of proportion runs throughout the whole work. Two whole pages are devoted to pernicious anæmia, and the same number to convulsions, one of the commonest symptoms of disordered infancy, whilst teething, and the symptoms so often associated with it, is not mentioned. Again, in the chapter on infant feeding, a page is given to the best methods of building a cow-shed, and the latest fashion in milking, whilst we are briefly told that the treatment of infective diarrhœa in infants that are hand fed, or only a few months old, is to "get a wet-nurse, or try asses' milk."

It is a pity that the author has omitted an account of the commoner patent foods. Amongst the poorer class of patients alone, the use and abuse of these methods of alternative feeding is so common, that it is necessary for the student to have some knowledge of their main constituents, so that he may be able to deal with such cases intelligently. We cannot agree with the author's terse judgment pronounced on them after a criticism of of six lines, "in every case they are undesirable as an infant's food, and should be avoided altogether."

The diseases of the circulatory organs are not as formidable as we suspected after reading the methods of examination of the heart that we are required to make. They are, in addition to inspection, palpation, etc., radiography, the use of the polygraph and electrocardiagraph. Luckily, the last two are left entirely to our imagination. The description of the fœtal circulation is hurried and careless.—"The umbilical vein joins the portal vein and passes through the liver," and "the ductus venosus passes through the liver."

The two chapters on the specific fevers are good. It is so common to find that writers on children's diseases leave this subject to the general medical textbook, where there is seldom room for the valuable account of the nursing, domestic arrangements and treatment so well described in this work. The description of the rashes is clear and the main points in the differential diagnoses clearly emphazied.

The general information in the last chapter should be very useful, though we think that the description of the Wassermann reaction would be profitably replaced by a brief account of the various dates at which a normal infant passes its "milestones"—holding up its head, sitting up, walking, etc. We venture to disagree with the remark that govage or forcible stomach feeding is indicated after operations on the mouth, cleft palate, and severe diphtheria, etc.; for all the author's indications we should prefer nasal feeding.

The plates are very good, but the subjects ill-chosen. Photographs of the typical adenoid, congenital syphilitic, cretin and mongolian facies would surely be of more value than the three plates of congenital dilatation of the colon.

On the whole it is a good work, and fulfils the object of the author in being a useful handbook to aid the student "whose first essential is attendance in the wards and out-patient department, where he will examine a child and cultivate his powers of observation, and learn to use his eyes more than his hands and his ears more than his tongue."

Manual of Surgery. By Alexis Thomson and Alexander Miles. Vol. III., Operative Surgery. Second Edition. (London: Henry Frowde, and Hodder & Stoughton.) Price 10s. 6d. net.

This third volume of Thomson and Miles is quite up to the standard of the better known first and second volumes. The authors have had the good sense to break away from the tradition which apparently insisted that every method of securing a particular surgical result should be, if possible, separately described, or at the least mentioned. As a result we are spared those wearisome lists of amputations and hernial operations, to mention only two examples, each associated with some bygone surgeon's name, which are such a feature of many students' hand-books. Instead, we get a description of one good method, and in many cases the name associated with that method has been allowed to lapse. It is a move in the right direction.

Every department of general surgery has been touched upon, and all the important procedures in each described. The descriptions, aided as they are by numerous and excellent illustrations, are exceptionally clear and commendably short. A short chapter on anæsthetics is included; it represents, of course, the Scotch view, and, therefore, finds more indications for chloroform than

would a London text-book, but the author has mercifully spared his readers any wearisome discussions on the merits of various pieces of anæsthetic apparatus. For that we thank him. A serious error, without doubt a printer's, occurs on page 586, where gr. $\frac{1}{12}$ of scopolamin is represented as a reasonable dose. On the whole we can thoroughly recommend this book to students and recently qualified men.

Aids to Public Health. By D. Somerville. (Baillière, Tindall & Cox.) Price 2s. 6d. cloth, 2s. paper.

The elaborate formulæ, mathematics, and equations included in this book make it too advanced to be of any value to the student revising his work for the ordinary final medical examinations, although it may, perhaps, be useful to men revising their work for the higher examinations. We are sorry that the publishers use such small and close-set type. It detracts from the value of any work to have such a depressing page to look at.

Sanatoria for the Tuberculous.—By F. R. Walters. (George Allen & Co.) Price 12s. 6d. net.

The fourth edition of this work appears at an opportune moment, and the wide-spread interest in the question of sanatoria which now prevails will doubtless win for it a deserved popularity. The bulk of the book is devoted to a classified account of the various sanatoria for the treatment of tuberculosis which are to be found throughout the world. The labour of collecting so many varied and valuable particulars must have been great, and Dr. Walters is to be congratulated upon having produced a practical and useful work of reference on the subject of sanatoria. The portion dealing with the general principles of sanatorium treatment is somewhat sketchy in character, but nevertheless provides a good outline of present-day views on the question. The chapters on classification and the results of treatment are worthy of careful perusal and contain many valuable suggestions. The book may be recommended as a useful and reliable handbook on a subject of great importance.

The Fæces of Children and Adults. By P. J. Cammidge, M.D. (Bristol: Messrs. John Wright & Sons.) Price 17s. 6d. net.

This book deals mainly with macroscopic, microscopic, and chemical methods of examination applicable to human fæces, and the conclusions to be drawn therefrom. The instructions are thoroughly practical, and many data, both normal and pathological, are included. The sections on parasites and bacteria are freely illustrated.

In view of the present general interest in disorders of the alimentary canal the book should prove of considerable value for reference, as it contains much information that is difficult to find elsewhere. The value of the bibliography given at the conclusion of each chapter would, however, have been greatly enhanced by the use of numbers referring to the text, as, unless the name of the author happens to be specified in the text, there is nothing to indicate the actual work referred to.

The last chapter and an appendix are devoted to the dietetic and medicinal treatment of various disturbances of function of the alimentary canal. The account is brief, and therefore necessarily didactic.

Appointments.

Medical School Appointments.

April—June, 1914.

Clinical Assistants.—Messrs. H. Sharpe, C. S. L. Roberts, J. York Moore, J. R. Barrow-Clough, C. F. Pedley, P. R. Boswell.

Clinical Assistants in Medical Wards.—Messrs. O. G. Parry-Jones, H. G. Dresing (Dr. Hale White), N. H. W. Saw, P. D. Scott (Sir Cooper Perry); A. S. Erulkar, A. H. Taymour (Dr. Shaw); H. H. Elliot, H. Parry-Price (Dr. Fawcett).

Clinical Assistant in Surgical Wards.—Mr. D. C. Scott (Mr. Steward).

Dressers in Special Departments:—

Throat and Ear, Children, Genito-Urinary.—Messrs. H. P. Whitworth, W. R. Pryn, F. L. Spalding, C. P. Symonds, E. J. Cooke, A. F. Rook, S. W. Coffin, R. A. Holmes.

Throat and Ear, Skin, Orthopædic.—Messrs. C. C. G. Gibson, M. Chadwick, B. Sampson, J. F. Mackenzie, W. L. Partridge.

Eye, Nervous System.—Messrs. L. Muir-Smith, E. W. Bowell, C. Lambrinudi, H. L. P. Peregrine (Mr. Eason); N. E. Kendall, G. D. Gripper, L. R. Broster, W. A. Easton (Mr. Ormond).

Obstetric Dressers.—Messrs. K. Westman, D. O. Richards, B. Burnside, R. W. P. Jackson, R. J. Quesada (G. B. Smith); W. L. E. Reynolds, J. S. Cocks, A. K. Day-Lewis, L. S. Fry, H. Q. V. Thompson, H. L. Messenger (Mr. Chapple).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. L. H. B. Evans, G. Noott, D. H. A. Galbraith (Dr. Hale White); J. J. Conybeare, F. A. Knott, C. H. Edwards (Sir Cooper Perry); V. R. Hirsch, K. N. Purkis (Dr. Shaw); V. E. Lloyd, E. Biddle, J. G. Jones (Dr. Fawcett). G. B. Dowling, C. H. Laver, W. H. A. Pratt, W. G. S. Neely, P. G. McEvedy, R. L. Portway, A. Bulleid, I. R. R. Brogden. (*P.M. Clerks.*—J. F. Carter-Braine, G. B. Tarring.)

Dental Surgeons' Dressers.—Messrs. C. Dean (May—June); G. L. Attwater (July—August).

Assistant Surgeons' Dressers.—Messrs. A. Traill, N. H. S. Maelzer, A. F. G. Guinness (Mr. Fagge); A. W. Cocking, E. M. Litchfield (Mr. Rowlands); A. D. Marston, E. C. de M. Morgan (Mr. Turner); E. S. Bowes, L. P. Waghorn (Mr. Hughes); A. G. East, J. B. Fairclough (Mr. Davies-Colley).

Surgeons' Dressers.—Messrs. R. Curle, K. L. Bates, A. Ascher (Sir W. Arbuthnot Lane); C. W. W. Baxter, M. J. T. Wallis (Mr. Dunn); J. E. Clark, J. G. Stevens (Sir Alfred Fripp); A. L. Punch, J. Ryle, G. S. B. Long (Mr. Steward).

Pathological Assistant to Demonstrators of Morbid Anatomy.—Mr. W. M. Lansdale.

Student Demonstrators of Microscopical Pathology.—Messrs. E. J. Cooke, G. L. Attwater.

Civil.

G. R. Phillips, M.R.C.S., L.R.C.P., to be Honorary Anæsthetist to St. Mary's Hospital, Paddington.

Skene Keith, M.B., B.S., to be House-Surgeon to All Saints' Hospital for Genito-Urinary Diseases, Vauxhall Bridge Road, S.W.

R. S. Kennedy, M.B., B.C. Cantab., Inspector, Ankylostoma Hospitals, Public Health Department, Egyptian Government.

Hildred B. Carlill, M.A., M.D. Cantab., M.R.C.P. Lond., appointed Assistant Physician to the Seamen's Hospital, Greenwich.

Naval and Military.

Capt. A. C. H. Gray, M.B., R.A.M.C., to be an Assistant Professor, *vice* Major S. L. Cummins, M.B., dated February 1st, 1914.

Lieutenant-Colonel T. B. Winter, R.A.M.C., to have charge of the Military Hospital, Canterbury.

In Lighter Vein.

Verses inspired by the contemplation of a Book Case.

As I sit brooding o'er the fire,
My weary eyes upturning,
A melancholy row of books
My fancy sets a-yearning.

I wish I were a *Taylor* poor,
Or e'en perhaps a *Barbour*,
For then I need not read the *Tomes*
My dusty bookshelves harbour.

I wish again that *May* were here,
T'were *Worth* a goodly ransom,
To see again the pastures *Green*,
The lilies *White* and handsome.

Some country *Lane* I long to tread,
With *Miles* of Land before me,
Leaving behind the dull *Gray* town
And *Rainy* skies that bore me.

I long to roam on *Heath* and *Hill*,
Midst *Underwood* and clover,
Where now and then a *Cunning Hare*
Darts timidly to cover.

A summer *Rose* would greatly cheer
My *Hart* so melancholy,
But I must fain be half content
With *Berry* red and holly.

Let *Wynters Savage* wrath descend,
With *Goodhart* I'll endeavour,
To *Still* the yearnings of my soul,
And quite ignore the weather!

L. M.

Rugby Football.

GUY'S v. OLD LEYSIANS.

This game was played at Wandsworth on February 28th and ended in a welcome win for the Hospital, 2 goals (one a penalty) and 2 tries to 2 placed goals, 14 points to 10. Without Parry-Jones, Kidman, and Tweed, we were scarcely at full strength in the pack. It was a very open and enjoyable game, the ball being taken from end to end with great rapidity and the varying fortunes of the two sides kept the play at a highly interesting pitch.

Steyn and Medlock ran strongly and for a time our three-quarters saw a good deal of the ball, but fully thirty minutes went by before the scoring commenced, the first try coming from Roberts who had a good opening made for him by Broster. Medlock did not majorise, neither had he any better fortune a little later when Steyn scored a try. The Old Leysians replied with an excellent try gained by Parke, who successfully got past several Guy's men and got over by the posts, J. Holloway goaling with ease.

After the interval N. J. Holloway made much ground for Parke to finish off a very fine three-quarter piece of play with another try, which was converted, and thus we were led by 4 points. Guy's got together more, and before long Medlock landed a useful penalty bringing us within one point of the Old Leysians. Playing with more spirit and putting in any amount of energetic footwork, our pack kept the Old Boys on the defensive, and just before the end Medlock passed to Broster who scored, Millett goaling from a difficult position. Team:—

Guy's.—H. Millett (back); C. L. Curle, A. H. Harkness, A. F. Guinness, S. L. Steyn (three-quarters); L. R. Broster, C. H. Medlock (halves); C. S. L. Roberts, A. B. Danby, A. S. Liebson, C. H. Laver, E. F. Llarena, H. P. Whitworth, B. Laver, —. Monk (forwards).

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

A STRIKING feature of the discussion which followed the address on Homœopathy recently delivered before the Physical Society by Dr. C. E. Wheeler was the scepticism of the value of drugs shown by most of the speakers. They were all recently-qualified men who were still holding resident appointments or had just finished their term of office. Each one in turn expressed the view that with the exception of less than a dozen drugs whose efficacy as curative agents was indubitable, most of the Pharmacopœia was valueless in the *cure* of disease. Listening to them one wondered whether they truly represented the modern view of drug therapy, or whether their pessimism was only the first result of a natural disappointment and disillusionment on discovering that the results of treatment with drugs were not commensurate with their expectations.

THIS disappointment is a natural, and, to some extent, an inevitable one, but we think it is unduly accentuated by a want of frankness on the part of our teachers, both in their textbooks and in their bedside discourses. We hear long disquisitions on the diagnosis and treatment of various diseases, and in our innocence carry away the substance of them in the belief that knowing how to diagnose, and how to treat a given condition, therefore, we are in a position to cure our patients. It is in many cases only after bitter experience that we realize the great gulf that usually intervenes between the treatment of a disease and its cure. In the bitterness of the reaction we usually swing too far over from blind belief to an almost equally blind disbelief, holding not only that most drugs are useless as curative agents, but that they are almost equally useless in the relief of symptoms.

Probably the truth lies between the two extremes of belief and disbelief, but it requires a little quiet reflection after the first shattering of our ideals before most of us realize this fact. Many, perhaps, fail to realize it at all, and still cling fondly to the illusion that it is only some difference in solubility or digestibility, which prevents a given drug from fulfilling the expectations raised, and so they ceaselessly and indiscriminately try every modification advertised by the manufacturing chemist. The recently qualified man would be spared much of this disappointment if his teachers were quite frank in telling him that nothing is known as to the cure of a majority of diseases, and that most drug treatment consists in attempting at times to relieve some of the more prominent symptoms.

WE are no longer in the position of our more credulous predecessors in the art of medicine, who apparently believed they *knew* what became of their drugs and exactly how they acted. It

is these bygone physicians, indeed, who are responsible for most of the traditional belief in a bottle of medicine, more especially as it exists among the laity, intelligent and educated, equally with the uneducated. In this connection it is interesting to note that over 300 years ago that shrewd old observer Montaigne made exactly the same criticisms of drug therapy as are current to-day. The passage is worthy of quotation in full.

"*The very promises of Physicke are incredible.* For being to provide for divers and contrary accidents, which often trouble us together, and with a kinde of necessary relation one unto another; as the heate of the liver and the cold of the stomacke, they will perswade us, that with their ingredients this one shall warm the stomacke, and this other coole the liver; the one hath charge to goe directly to the reynes, yea, even to the bladder, without enstalling his operation anywhere else, and by reason of it's secret propriety, keeping his force and vertue, all that long way, and so full of stops or lets, untill it come to the place, to whose service it is destinated. Another shall drie the braine, and another moisten the lungs. Of all this hotch-pot having composed a mixture or portion, *is it not a kind of raving, to hope their severall vertues shall divide and separate themselves from out such a confusion or commixture, to run to so divers charges?* I should greatly feare they would lose or change their tickets and trouble their quarters. And who can imagine, that in this liquid confusion, these faculties be not corrupted, confounded and alter one another?" (Booke II, Chap. 37.)

Apropos of the note in Passim a fortnight ago on the arrangements recently made to facilitate the examination of microscopic sections of post-mortem and operation specimens, it has been suggested to us that the School authorities might with advantage further extend their activities in this direction by establishing a complete and permanent collection of slides illustrating both normal and pathological histology, which would be available for the use of the men. The suggestion seems to us a very good one, and one well worthy of consideration. Such a series would be extremely valuable to men who are reading for examinations, or who wish to refresh their memories from time to time on the appearance of any particular condition. It would supplement the course in morbid histology in much the same manner that the Museum supplements the experience gained in the post-mortem room. We imagine that the provision of a fairly complete series of all common conditions would present no special difficulties, and accommodation for the specimens should be as easily provided either in the Library or the Pathological Department. The only real difficulty we can foresee lies in the regulations for access to the collections. Histological slides are easily broken or damaged, and display an astonishing facility for losing themselves, or at least for disappearing suddenly. They seem, indeed, to be almost as difficult to hold as an interesting or valuable book. This difficulty could, however, be overcome by suitable regulations such as those used in libraries.

We referred some time ago to the complaints which have been constantly raised since a telephone was first installed in the Students' Club some few years ago. The chief grievance was that the telephone was not available by members free of cost, but that they were obliged to pay for every call. The complaint was a perfectly justifiable one, since the telephone is placed in the noisiest part of the College, and there is not even the privacy of a telephone box, and we expressed the hope at the time that the Students' Club would be able to make more satisfactory arrangements, and would also, if possible, enable men to use the telephone free of charge.

The difficulty is a purely financial one, and the ultimate decision rests, of course, with the Clubs' Union, which controls the funds of all the constituent institutions. The Clubs' Union has been approached by the Students' Club with a request for an increased grant for the purpose of improving the telephone facilities, and has agreed to increase the Students' Club grant by an amount sufficient to allow of a reduction in the price of the tele-

phone calls to a penny. This concession will not, of course, completely satisfy everyone, but at least men will get their telephone more cheaply, if not so conveniently, as in a public call-office.

A box will be placed beside the telephone as heretofore, into which every member making a call must place a penny. These pennies will be collected by the Students' Club, and used to defray in part the cost of the telephone. It is hoped that every member of the club will loyally carry out the new arrangement, as the Clubs' Union is unable to provide sufficient money to instal a telephone free of charge, and will be compelled to discontinue the telephone altogether unless a sufficient number of pennies are placed in the box.

The Physical Society will hold the last meeting of the session this evening (Saturday, March 28th) at 8 p.m., in the College Smoking Room. Mr. F. J. Steward will take the chair, and will announce the winner of the Treasurer's Prize Essay for the year. The subject chosen was "Surgical Shock." The question is one of great interest and importance, and, perhaps, of even greater difficulty and complexity, and, therefore, a clear and impartial discussion of the current views as to the ætiology, prevention or treatment of the condition, such as one may reasonably expect from the successful competitor, will enable those present to form a more or less definite opinion on the subject. At the same meeting the awards of the Society's Prizes to those members who have shown the most interesting cases and specimens, and who have most distinguished themselves in discussion will also be announced.

Pass List.

University of Cambridge.

Degrees Conferred.

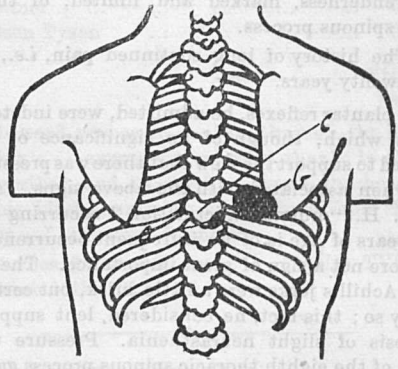
M.B., B.C.—A. C. Clifford. | M.B.—J. M. Jarvie.

The Difficulties of Early Spinal Caries.

"Who shall decide when doctors disagree?"—*Pope.*
Moral Essays, III. i.

Mr. John B., aged 50, a master builder, complains of a pain in his back. He has had a very athletic career and played association football until he was nearly forty years of age; since giving up the game he has become rather stout. In 1893, while engaged for West Bromwich Albion, Mr. B. was struck in the back by another player's knee. Taking no notice of the blow at the time, he continued playing, but subsequently the site of the injury caused him considerable discomfort. Dr. A., whom he consulted, told him the alarming fact that his "liver was displaced." After two or three months, however, the pain disappeared and he resumed his football. Ever since, that is for more than twenty years, he has experienced this pain with intermissions at various intervals. He suffers from extreme nervousness and the slightest worry causes him to be inordinately depressed and irritable.

Mr. B. indicates as the seat of his pain a small area between the right scapula and the spinal column. This is illustrated in the following diagram:—



a = a subcutaneous nævus almost ¾ in. in diameter.
b = the area indicated as the situation of pain.
c = the eighth thoracic vertebra.

About a month ago, having an attack of pain and consequently feeling somewhat despondent, he consulted Dr. C., who informed him, after a casual examination, that he had "ruptured his liver." This diagnosis rather frightened Mr. B., so he at once went to Birmingham and saw a consultant, Dr. X. This latter physician examined the patient very carefully, and arrived at the conclusion that the trouble was due to early spinal caries; he found present certain signs which he considered indicative of pressure upon the spinal cord, and, therefore, advised immobilisation of the spine in a poroplastic jacket.

Still B. was dissatisfied. He then interviewed Dr. E. who told him in homely fashion that he was suffering from lumbago. Liniment was prescribed and used, which, for the time being, gave the patient complete relief. Later, in his search for two concurrent opinions, Mr. B. consulted Mr. F., telling him all that Dr. X. had said of the complaint. Incidentally, it was with Dr. X.'s exhaustive examination of his nervous system that the patient was most impressed. Mr. F. was an orthopædic surgeon, and agreed that the case was one of very early spinal caries. Complete rest for not less than six months in the supine position was enjoined. This treatment, however, did not appeal to John B., who decided to ask Dr. H's. advice. This gentleman could not agree with the diagnosis of spinal caries, as in his opinion there were no pressure symptoms. The pain, he considered, was referred from the stomach during attacks of "indigestion," or to be more accurate, the man was slightly neurasthenic, and suffered from gastric atony. He demonstrated, both to his own and Mr. B.'s satisfaction, that the spinal tenderness was quite superficial, and due to a small subcutaneous nævus situated immediately to the right of the eighth dorsal spinous process.

Dr. X., had considered the following facts significant of spinal caries with pressure symptoms :—

1. Hurried micturition for a year or more.

2. Increased knee and tendo-Achillis jerks and the presence of a crossed adductor reflex of the thighs.

3. Tenderness, marked and limited, of the eighth dorsal spinous process.

4. The history of long continued pain, *i.e.*, for more than twenty years.

The plantar reflexes, he admitted, were indeterminate, a fact which, though of no significance of itself, he believed to support the view that there was pressure on the cord when associated with the above signs. According to Dr. H. "hurried micturition" occurring in a man fifty years of age is of no infrequent occurrence, and is therefore not a sign of great importance. The knee and tendo-Achillis jerks were a little brisk, but certainly not unduly so; this fact, he considered, lent support to his diagnosis of slight neurasthenia. Pressure upon the region of the eighth thoracic spinous process gave rise to pain, but in this area there is a nævus chiefly subcutaneous. This latter structure was tender but on drawing it and the skin over to the right, and so away from the vertebral column, no tenderness was experienced when the eighth and adjacent spinous processes were firmly pressed upon with a knife handle. Pain, however, was still felt on palpating the nævus.

Therefore, Dr. H. assured B. that if the nævus were removed, all tenderness would disappear. In addition to the few abnormalities of the nervous system observed by Dr. X., he found that there were no abdominal nor epigastric reflexes. This he put down to the stoutness of the patient's abdomen, particularly as the cremasteric reflexes were unchanged. He agreed with the previous observers that the nervous system was otherwise normal, but went a little farther than they in that he advised an X-ray examination.

The history, rather than favouring the presence of spinal caries, seemed decidedly against it. In nearly twenty years, had the pain been due to such a condition during the whole of this period, the man would surely show more definite signs of the disease. In fact, a shorter history would have been far more suggestive. Such considerations, together with the fact that the spine showed no rigidity nor the slightest pain on movement, induced Dr. H. to arrive at the conclusion previously stated.

In the meantime Mr. John B., probably still unconvinced, is leading an ordinary life, pondering upon the vagaries of the medical profession, and wondering what the end will be. If the term "doctors" is regarded in its present-day popular sense, to which, of course, Pope did not necessarily confine it, I have often thought that the only possible answer to his question is—Time or an autopsy.

From this case we have certain facts recalled to us. Firstly, that the diagnosis of early spinal caries is a matter of extreme difficulty; secondly, the importance of an exhaustive examination; thirdly, that the knee jerks vary considerably in their briskness in different individuals, and in neurasthenia they are often slightly exaggerated; fourthly, that in stout subjects the abdominal and epigastric reflexes are difficult to obtain, and may appear to be absent; and lastly, always to secure a radiographic examination in cases where there exists any doubt as to the true condition.

N.B.—It is interesting to note that the X-rays revealed no abnormality of the spine,

CECIL WORSTER-DROUGHT.

Papers by Guy's Men.

McGavin, Lawrie, F.R.C.S.: Two Lectures on Spinal Analgesia; Lecture II.—*Clinical Journal*, March 18th, 1914.

Steward, F. J., M.S., F.R.C.S.: Affections of the Umbilicus.—*Clinical Journal*, March 18th, 1914.

Starling, Prof. E. H., M.D., F.R.C.P., F.R.S.: Therapeutic Valve of Hormones; Proc. Roy. Soc. Med., Therap. and Pharmacol. Sect., February, 1914. 29.

Shufflebotham, F., M.A., M.D., J.P.: The Milroy Lectures.—Lecture III., Dust.—Lecture IV., Miners' Nystagmus.—*British Medical Journal*, March 14th and 21st, 1914.

Myer, Leonard, F.R.C.S., Edin.: A Case of Quinine Poisoning.—*Lancet*, March 21st, 1914.

PERIODICALS RECEIVED.—Hospital, Nursing Times, Clinical Journal, The M.S. Journal, British Medical Journal, Middlesex Hospital Journal, Clinical Excerpts.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Matriarchy.

Dear Sir,—I have read the paper on "Eugenics and some Modern Social Problems," which was published in the Guy's Gazette of January 31st, with very great interest. The writer's remarks have thrown for me a new light on the vexed question of Female Suffrage, and his arguments in favour of it seem to me to carry considerable weight.

His mention of the existence of a tribe in Central Africa which shows traces of Matriarchy reminds me that there is a tribe living in the hills on the south of the Brahmaputra Valley among whom the Matriarchal theory of inheritance is still in full force.

They call themselves "Khasis." They belong to the great Indo-Chinese race, and they are supposed to have come originally from North West China, and to belong to one of the earliest bands of emigrants from that region. Their language, which was unwritten until recently, is quite unlike that of any other of the tribes surrounding them, and it is connected with the languages which are spoken by some of the tribes living in Anam and Cambodia.

In this tribe the woman is considered to be the head of the family. Tribal descent goes through the female line, and the youngest daughter is the heir to the family property. The elder daughters, when they marry, go to live in the homes of their husbands, but when the youngest daughter marries she remains in the maternal home, and her husband comes to live with her.

The marriage ties are loose. Union between the sexes can be terminated by mutual consent or by the will of either party. The offspring are dependent chiefly upon the mother, and the identity of the father is a matter of comparatively small importance.

The result of this loose arrangement is that adultery is uncommon, and the people have no temptation to embark on secret intrigues. The woman throughout life remains, if not the predominant partner, at least of equal importance with the man.

These customs are extremely primitive, and are comparable in some respects to the conditions of life among a herd of cattle, but they seem to me to compare very favourably, as regards the position of the woman, with the customs of some more highly civilized communities.—I am, Sir, yours faithfully,

Ranchi, OBSERVER.
February, 1914.

The Milward Fund.

Dear Sir,—I shall be much obliged if you will kindly insert in your next issue the enclosed list of subscriptions, sent by past members of the nursing staff at Guy's to Mrs. Courtenay Milward:—

	£	s.	d.
Miss Fox	1	1	0
Miss Bayliss	1	1	0
Mrs. Pike	1	1	0
Miss Hyland	0	2	6
Miss L. Taylor	0	10	0
Miss A. M. Timbrell	0	10	6
Mrs. Meredith	1	1	0
Mrs. Rowlands (E.W.S.)	0	10	6
Mrs. H. Higgens	2	2	0
Miss Livermore	0	2	6
Mrs. Hinchliff	1	0	0
Mrs Lewis	0	10	6
Miss K. Brereton	1	10	0
Mrs. C. H. Fagge	0	5	0
Mrs. C. D. Edwards	0	10	0
Miss K. Oyler	0	5	0
The Misses Rickwood	0	10	0
"Heathen"	0	10	0
Miss C. Iles	0	2	0
Miss F. Tubbs	0	5	0
Mrs. Elliott	1	1	0
Miss Hanmer	0	5	0
Mrs. Wilson Tyson	0	10	6
Total	£15	6	0

Mrs. Milward wishes to convey, through the medium of the Guy's Gazette, her grateful thanks to all those who subscribed, and to say how much she has appreciated this kind expression of goodwill from her old colleagues.—I am, yours faithfully,

The Beeches, Lowestoft. MAUD TYSON.
March 15th, 1914.

Specialities.

Antisclerosin.

It is claimed for this preparation that it is valuable in the treatment of many of the symptoms of arterio-sclerosis, especially pains in the calves, giddiness, and headache, and the dry irritating cough often complained of. The tablets are said to consist of sodium chloride, sodium sulphate, sodium phosphate, sodium carbonate, magnesium phosphate, and calcium glycero-phosphate in physiological proportions, and to exercise a specific action upon the walls of the blood-vessels. It is not put forward as a cure for arterio-sclerosis, but merely as a means of relief for the distressing symptoms of the disease.

A Case of Adenomata of the Liver.

Florence C., æt. 31, a cigarette-maker, was admitted under Sir Alfred Fripp for acute intestinal obstruction. There was nothing of importance in the family history, and it is stated that she had always been very healthy. Her face was much disfigured by syphilis.

The day before admission patient went to work feeling very well. On returning home that night she felt unwell, and could keep no food down. She was able to sip liquids, but was unable to keep a dose of castor-oil down. Her bowels had been regular till this day, when she did not pass a motion. Her abdomen was slightly distended and painful to touch. There was no history of a blow, or of injury of any sort.

The next day (the day of admission) patient's abdomen was more distended, and her pulse was increasing in rate hourly. The abdomen was not rigid; it moved well on respiration, and was dull all over on percussion. The urine was normal. On making a rectal examination a large soft mass could be felt in the pouch of Douglas. Patient vomited last ten hours before admission. She had not passed a motion since the onset of her illness. Her temperature was 99°F.; pulse, 150; respirations, 30. The pallor of the patient suggested a possibility of ruptured ectopic—but no history pointing to this could be obtained.

Turpentine enemas having had no effect, it was decided to operate. An incision was made in the mid-line about four inches in extent. As soon as the peritoneum was opened a large quantity of dark-coloured blood welled out.

On examining the organs in the pelvis it was found that they were quite healthy and were not the cause of the hæmorrhage. On examining the liver, a large mass, with the appearance of a "seven months' uterus," was found to be attached to the posterior surface of the right lobe of the liver. The hæmorrhage was issuing from a rupture in this mass. This tumour was soft and friable "like placenta," so preventing the closure of the rent by sutures. The mass was removed by means of a cautery and the bleeding stopped by cauterisation. Hæmorrhage was very readily controlled by the cautery. A large rubber drain was inserted and the wound well packed. Patient was infused with saline and pituitary extract, but died soon after her return to bed. There was no history of a blow or anything to show why hæmorrhage had suddenly started (? cause of bleeding).

At the autopsy the stomach and duodenum were found to be normal in size and contained much bile. The growth which was removed proved to be a Riedl's lobe containing an adenoma. A second adenoma about half an inch in size was found on the anterior surface of the right lobe at the autopsy. Adenomata of the liver may be single or multiple. They are rare and are almost always solitary in man; in dogs they are commonly multiple and are quite small. They may develop from the hepatic cells or from the biliary ducts. They are perfectly well-defined tumours having the same structure as proper hepatic tissue except that the cells may be a little larger than usual. These often have double nuclei, and may have a slight increase of fibrous tissue between them. The rest of the hepatic tissue is healthy. The biliary duct adenoma may become the seat of cystic dilatation (cyst adenoma).

Naked-eye appearance of this mass.—It measures roughly, in the hardened specimen, $6 \times 6 \times 2\frac{1}{2}$ inches. It is lenticular shaped and somewhat more flattened on the posterior than on the anterior surface; it is also slightly irregular. It was attached to the liver by a broad pedicle. A cut section shows that the whole of the tumour is traversed longitudinally by a fissure which measures over five inches in length and is filled with blood-clot. The substance of the tumour is mottled, being composed of pale greyish and dark-greenish patches, and is somewhat granular. The tumour is separated everywhere from the rest of the liver by a thin fibrous septum.

Microscopical appearances.—The accessory lobe is covered by a definite hepatic capsule; it is composed of liver lobules with definite portal canals, many of these—even on the surface—showing necrosis and fatty degeneration of the liver cells. As the centre is reached these changes become more marked. Nearer still to the centre, the liver substance is infiltrated with blood, so that nothing is to be seen except a clot in which there are a few degenerated remains of liver cells.

The adenoma in this lobe is imperfectly encapsuled, merging over the greater part of its circumference into the surrounding liver. It is composed of groups of somewhat œdematous cells which closely resemble those of the liver. These are separated from each other by a fibrinous material (which stains red with eosin) in which there are a few leucocytes and which contains a fair number of capillary blood-vessels, each of which is surrounded by a definite, though thin, wall.

The adenoma found at the autopsy.—This adenoma is situated immediately under the capsule. It merges everywhere into the liver substance, and is composed of cells which closely resemble those of the liver, except for being somewhat larger and for containing bigger, more vesicular nuclei. These cells are arranged in imperfect alveoli by means of thin bands of connective tissue between them. Each of these bands contain one or more thin-walled blood-vessels, but show no indications of definite portal canals or biliary ducts. I am greatly indebted to Mr. Turner and Dr. Nicholson for advice in preparing these notes.

H. THOMPSON.

Some Renal Cases.

CLINICAL LECTURE BY RALPH THOMPSON, Ch.M., F.R.C.S.

Gentlemen,—I will ask you to consider with me this afternoon a case in which nephrectomy was performed in May of last year. The patient is a lady of active habits, unmarried, and aged 47. Two years ago I saw her in consultation. She showed the following symptoms: There was pain in both loins, especially on the left side. This pain was of such a severe nature that she had not been able to lie on her left side for some years. There was also pyuria. She was skiagraphed, and a stone discovered in the right kidney. The left kidney was found to be acting well after both ureters had been catheterised. So the right kidney was exposed and a stone removed. The patient quickly recovered from the operation, but three months afterwards she again complained of right-sided pain.

I will ask you to note that she no longer complained of any left-sided pain. I may add that both kidneys were palpable, but not enlarged. She was again skiagraphed, and two stones located in the renal region. She was again operated upon and the two stones removed. I had not received permission to do a nephrectomy, and as there was clinical evidence of the left kidney not being quite sound, I was indeed unwilling to do such an operation. As, however, there was a good deal of pus and calculous debris in the right kidney, I felt that the prognosis was not very good. The patient made fairly good progress for six months, but in May, 1913, she again complained of right-sided pain and pyuria. Skiagraphic evidence of calculi was forthcoming, so, after consultation with Dr. Philip Savill, of Bexhill, I decided to again explore the right kidney. This kidney was therefore exposed and found to be small and contracted and when opened to be full of pus and calculous debris.

We decided, therefore, that, as the left kidney was acting well, and as there were no signs of urea retention in the blood, it would be advisable to excise the kidney. This was done, and when the kidney was examined it was found to be full of bacillus coli, and much inflamed. I think, therefore, we were justified in excising the kidney. The patient now made very good progress, and appeared to get quite well until November, 1913, when one night she was awakened by violent pain on the left side, and the passage of calculous debris from the bladder. She was again skiagraphed, with negative results. She came up to London to see me, and Dr. Stanley Melville skiagraphed her, but could not find any evidence of calculous formation. We knew that the kidney was low, and thought that perhaps a kink of the ureter had produced the symptoms. On the very day that she was skiagraphed, the 20th December, 1913, she ceased to pass any urine. The cessa- of the flow was quite sudden. I saw her on the 22nd of December, when the following manifestations of disease were noted. No urine had been passed, nor was there any in the bladder. There was considerable pain over the left lumbar and iliac regions, but no definite enlargement of the kidney, which was displaced downwards. There were dark rings round the eyes, œdema of the forehead, and great frontal pain. Patient felt very sick, and occasionally vomited.

I, therefore, feeling that one ought to proceed cautiously, passed a small ureteric catheter up the left ureter: found no obstruction and left it in. The pelvis of the left kidney was washed with hot boracic lotion, and a dark-coloured urine containing 1 per cent. of urea began at once to be secreted. During the next thirty-six hours the patient passed about twenty ounces of urine, which was opaque and contained bacillus coli. The catheter, being a small one, came out of itself, and again no urine was passed. As the previous symptoms re-appeared at once I decided to pass a larger catheter.

On cystoscopic examination of the bladder it was noted that there was considerable papil-

liferous proliferation of the epithelium round the orifice of the left ureter. The large catheter during its passage up the left ureter encountered no obstruction. You will remember the last X-ray examination was negative. This catheter showed no tendency to come out, and during the next four days about twenty ounces of urine were passed per diem.

I now had the advantage of a consultation with Mr. Frank Kidd, who agreed with me that the continued presence of the ureteric catheter could only do harm by producing ureteritis, and that an exploratory operation should be performed. This was done. The kidney was exposed and incised. It was healthy. The pelvis was considerably dilated, but no actual obstruction, such as a stone or aberrant vessel, found. A large tube was placed through the renal wound into the pelvis of the kidney and sutured in position. The patient at once secreted urine, not only through the tube, but also through the ureter, and continued to do so for eleven days, when gradually the urine coming by the ureter ceased running, and at the end of fifteen days from the operation all the urinary fluid came through the nephrotomy wound. The wound gradually closed up, but a lumbar sinus remained through which all the urine came away.

The patient at the end of six weeks was very much better, but said that she would rather die than have a lumbar sinus discharging urine. After further consultation she agreed to any operation which might be considered advisable. I felt myself that the outlook, both immediate and remote, was very poor indeed, but also felt that the patient was right in asking that something should be done. She had now been lying in bed for over two months, and I thought she might not take the anæsthetic at all well, or stand the shock of the operation.

On the 23rd of February, 1914, Dr. Depree gave an anæsthetic, and I again cut down on the left kidney. The pelvis was found much more dilated than it was before. In a very short time Dr. Depree reported that the patient was very bad indeed. Fortunately the twelfth rib happened to be long and projected into the wound. I hastily put two catgut sutures through the kidney and round the twelfth rib, getting the kidney as high up as I possibly could. A tube was placed in the wound and the patient put back to bed. The foot of the bed was raised as high as possible. The patient's condition caused great anxiety for two or three hours, but from the moment of the operation being completed she passed her urine the normal way, and has continued so to do since the operation. The lumbar wound is healing up, although there is a tendency for some urine to come that way. About a fortnight after the operation she passed a small stone which had clearly passed through the ureter.

Now although this case is one of extreme interest from the point of view of diagnosis; and neither operation, nor catheterisation of the ureter, nor X-ray photographs have cleared up its doubtful nature, yet I have recorded its details to you, as it gives us one of the aspects of the after-history of nephrectomy. Nothing can justify a nephrectomy unless the continued presence of a diseased kidney is likely to shorten life, or unless it has ceased to functionate. It is unfortunate that in many people's minds nephrectomy is considered to be an easy operation. This is not my own opinion, but several medical men do regard it as such. For this reason I venture to think that nephrectomy is done without due regard to other possibilities. There is another point with regard to nephrectomy which deserves our attention. You know that in every disease the right kidney is more commonly affected than the left. If care, then, is necessary in deciding about a right nephrectomy, greater care still will be necessary in deciding as to a left nephrectomy.

I wish now to tell you about another case of nephrectomy. At the end of last year a patient was admitted under Dr. Shaw's care. She came from Dr. Johnson, of Islington, and gave the following history. She had had her right kidney removed eight years ago by Mr. Golding-Bird at Guy's. For what condition it was removed is not clear from the report. Some time ago she complained of pain in the left side, and had pyuria, and was seen by Dr. French,

who examined her and sent her into Guy's. She then had pain on the left side. She was examined, and with the aid of the cystoscope we saw a vermicular mass of inspissated pus at the orifice of the right ureter. The left ureteric orifice and the urine coming through it appeared normal. It was decided to explore the right side. I may say that the wound of the previous operation was in perfect condition and one of the most satisfactory I have ever seen. Before the second operation was begun a distinct swelling was felt in the right lumbar and iliac regions of the abdomen.

My incision exposed a structure of the exact shape and size of a kidney connected with the ureter, but having no vessels. It was found to be a bag of pus in connection with the ureter. If and when you remove a kidney, I should advise you to treat the stump of the ureter as carefully as you would the appendix, and to divide it with a cautery between two ligatures. If, then, nephrectomy is such a grave matter, you will ask what should be done instead.

For a suppurating kidney a plain nephrectomy may be performed provided that you lay the abscesses well open. I was taught this fact practically by a case Dr. French asked me to see some fifteen months ago. A young married woman who had recently had a baby was admitted into Guy's for right-sided lumbar pain, right rigidity of the abdomen, a high intermittent temperature, and pyuria. She was very ill. I examined her bladder with the cystoscope, and examined the urine from either kidney. That from the left was normal; there was a diminished quantity from the right and it contained pus.

I incised the kidney region by the lumbar route and exposed the kidney. This was firmly adherent to the peritoneum which lay in front of it, so adherent that I did not dare to remove the kidney, as I felt certain the peritoneum would be opened, so I contented myself with laying the kidney open from end to end, and thus incising three separate abscesses in the kidney. There was healthy renal tissue left. The resulting wound was plugged with gauze and drained. It healed up well, and the patient was very well some twelve months afterwards, when she showed me a second fine child which had recently been born.

In certain cases of hydronephrosis, even when the kidney is nearly atrophied, I think you would be justified in attempting a short circuit between the ureter and the renal pelvis. Cornelius T., aged 35 or thereby, was sent up by Dr. R. E. French for a large left lumbar swelling which was diagnosed as hydronephrosis. Bearing in mind that the left kidney was affected and that there was some evidence of a similar condition on the right side, I decided to perform a plastic operation. A longitudinal slit was made in the left ureter near the pelvis of the kidney, and an oval hole cut out of the lower part of the pelvis of the kidney. These two orifices were united at their edges by means of a suture which Sir Arbuthnot Lane used to use for intestinal anastomosis, but which, I believe he has given up. A ureteric catheter was passed from above downwards through an incision in the kidney (into which a rubber drainage tube was also inserted) and passed through the anastomosis as far as the bladder. Although there was only about half the left kidney present, the patient did perfectly well and the wound healed well. Now, ten months after the operation, Dr. R. E. French tells me that the patient has done very well.

Summary.

The first case I related to you to-day shows the after-history of a nephrectomy, a nephrectomy which, I believe was absolutely justified when a complete examination was made of it microscopically and macroscopically.

The second case illustrates the possibility of a residual abscess occurring in relation to the stump of the ureter.

The third case illustrates the value of a plain incision in some cases of renal suppuration.

The fourth case illustrates the value of a ureto-pyelostomy in cases of even advanced hydronephrosis.

Guy's Hospital.

An Abstract of the Returns of the Bacteriological and Vaccine Department for 1913.

Total number of specimens examined in the Bacteriological Department, classified according to the Department of the Hospital from which each was derived, during the year 1913:—

Medical Wards	687
Clinical Wards	609
Surgical Wards	871
Post-mortem Room	119
Out-Patient Department	1,632
Casualty Department—Front Surgery	1,413
Unclassified	1,350
Total, 1913	6,681
Total, 1912	7,019

Total number of specimens examined in the Bacteriological Department during each month of the year 1913:—

January	606
February	525
March	467
April	515
May	505
June	532
July	630
August	579
September	581
October	644
November	582
December	515
Total, 1913	6,681
Total, 1912	7,019

Vaccine In-Patients.

	1913	1912
Medical	90	94
Surgical	89	82

Vaccine Out-Patients.

	Total 1913.	Total 1912.	Total 1911.	Total 1910.
No. of Letters Issued	424	307	314	234
No. of Attendances	2,706	2,273	2,343	2,145
No. of doses administered:				
Tuberculin	733	656	848	1,030
Vaccine	1,180	1,070	990	671

Autogenous Vaccines Prepared.

1913	337
1912	408

Apparatus supplied to the Hospital Stores (for the collection of specimens) by the Bacteriological Department during the twelve months ending December 31st, 1913.

	Total.
Serum Tubes	1,692
Sterile Swabs	2,724
Widal Pipettes	96
Sterile Tubes	972
P. M. Pipettes	1 case
Fæces Tubes	108
Urine Bottles	492
Sputum Pots	648

Summary of Cost of Supplies.

	£	s.	d.
Diphtheria outfits (1,692) 141 dozen at 4s.	28	4	0
Sterile Swabs (2,724) 227 dozen at 1s.	11	7	0
Widal Pipettes (96) 8 dozen at 6d.	0	4	0
Sterile Tubes (972) 81 dozen at 9d.	3	0	9
Fæces Tubes (108) 9 dozen at 1s. 6d.	0	13	6
Sputum Bottles (432) 36 dozen at 4s. (Jan.–July)	7	4	0
Sputum Pots (216) 18 dozen at 6d. (Aug.–Dec.)	0	9	0
Urine Bottles (492) 41 dozen at 10d.	1	14	2
P. M. Pipettes, 1 case, at 1s. 6d. each	0	1	6
	£52	17	11

Complement Fixation Tests carried out during 1913.

Month.	No.
January	65
February	51
March	42
April	72
May	54
June	57
July	58
August	77
September	50
October	84
November	74
December	73
Total	757

Salvarsan Apparatus supplied ... 172

[The number of doses of Salvarsan and Neo-Salvarsan issued from the dispensary during the last four years was as follows:—

	1910.	1911.	1912.	1913.
Salvarsan	12	156	282	179
Neo-Salvarsan	—	—	12	140
Total	12	156	294	319

The discrepancy between the amount of these drugs used and the number of salvarsan apparatus supplied by the bacteriological Department in 1913 is probably due to the fact that a considerable number of intra-muscular injections of Neo-Salvarsan are given to out-patients.—Editor.]

ACCOUNT OF SURGICAL DRESSINGS, &c., supplied to the Wards during the year 1913:—

Name of Wards.	£	s.	d.
Astley Cooper	127	0	3
Cornelius	111	1	5
Lazarus	78	9	11
Job	112	6	10
Naaman	93	16	5
Luke	72	11	2
Patience and Samaritan	153	3	5
Charity	81	1	10
Dorcas	101	11	5
Lydia	114	10	3
Martha	161	15	5
Eye Wards	65	5	5
Addison	67	14	4
Mary	66	17	9
Stephen	60	8	9
Esther	21	19	0
Bright	84	0	5
Queen Victoria	112	8	3
Clinical	105	5	9
Isolation	27	14	3
Theatres	30	7	10
Front Surgery	258	12	7
Back Surgery	275	1	9
Out-Patients	439	13	11
Electrical Department	40	3	1
Maternity Charity	46	16	10
The Nurses' Sick Room	11	12	0
Total	£2,921	10	3
Total cost last year ...	£3,037	3	5

Presentation.

On Wednesday evening, March 18th, at Colchester, a complimentary dinner was given by the members of the North East Essex Division of the British Medical Association to Dr. W. Leigh Day, Dr. W. F. A. Clowes, and Dr. Stanley Worts, in recognition of their strenuous efforts on behalf of the profession during the fight against the Insurance Act. During the evening each of these gentlemen was presented with a silver bowl suitably engraved, the presentation being made by Dr. J. H. Salter, who presided at the dinner.

Gazette Special Pathologist.

S. C. C., MARTOCK.—This material is so badly preserved that we feel an accurate diagnosis is impossible. At the same time, we have no doubt that it is from a malignant growth. As far as the material serves, the appearances suggest that the growth is a squamous epithelioma. PATHOLOGIST.

A Case of Angeioma of the Bladder.

BY E. S. TAYLOR, M.B., B.C.

ANGEIOMA of the bladder had long been recognised as a true pathological condition before the introduction and more general use of the cystoscope, but even now it is a condition of extreme rarity, and the following case is almost unique in that the varices composing the angeioma contained concretions or phleboliths, which were opaque to the X-rays and could be easily seen in a skiagram.

Fanny K., aged 44, a patient of Dr. Wildridge, of Sunningdale, was admitted under Mr. Rowlands in October, 1913, for pain in the left loin; she was married and had six children.

Her previous history is important: Since the age of seven she had passed blood in the urine intermittently, at intervals ranging from three months to nine years, and this hæmaturia was sometimes very severe, lasting usually about one month, with the occasional passage of blood-clots, which caused much pain, apparently from obstruction, and resulted in much temporary weakness. Nine years before admission the patient first experienced a pain in the small of her back, which has continued, more or less, ever since, and for the last three years this pain has become dull and continuous without any connection with the periods of hæmaturia. The bleeding occurred twice during pregnancies, and the last attack continued for two months and ceased one month before admission.

On examination the patient was found to be a healthy, well-nourished woman; she complained of a continuous dull pain over an area of about three inches and one inch external to the left posterior superior iliac spine, which showed slight tenderness on deep palpation. The temperature was normal. The skiagram of the pelvis showed small round masses, opaque to the X-rays, arranged roughly in two distinct groups, one on each side of the middle line, and just above the level of the rami of the pubes.

The urine, on examination, was found to be entirely free from blood, pus, or micro-organisms, and cultivation from it remained sterile.

Examination with the cystoscope showed that the anterior wall and right half of the bladder were occupied by a large nævus. This was pigmented in parts, showing dark patches, some the size of a pea and of a dense black appearance, and others larger in size and less black. No stones were present in the bladder and clear urine flowed from each ureteral orifice.

Mr. Rowlands decided that the appearances were those of varices of the bladder, which contained phleboliths and constituted an angeioma. He considered that its extensive character made operation for its removal impossible.

Angeiomata of the bladder are not recognised by some English authorities who consider that when they have

been described, they have really been varices of the neck of the organ, but Cheyne and Burghard give notes of a case in which the left side of the bladder was occupied by an angeiomatous growth, of which the only symptom was hæmorrhage, without any indication of its true source, and so profuse as to prevent satisfactory cystoscopic examination.

The diagnosis has often to be made partly by exclusion, and partly by the existence, as in their case, of well-marked cutaneous nævi in the neighbourhood of the pelvis.

Mr. Rowlands' patient had no other nævi, but an authority, whom I shall quote later, mentions a case in which the association was well-marked.

Hertzhr[1] describes hæmangeiomas or telangiectases as having been reported in the bladder, and he considers that they usually appear as an extension of similar dilatations of other pelvic veins.

Bachrach[2], writing in 1910 has collected all the reported cases of this condition, and considers that bleeding from varices of the bladder is comparatively rare, and was much more often diagnosed before the introduction of the cystoscope than appears now to have been justifiable. Some of the oldest observers mention cases of fatal bleeding from "hæmorrhoids" of the bladder, and Vôrchow describes dilatations of the submucous veins which surround the proximal end of the urethra though he observed no large bleeding from these, nor did he see any true hæmorrhoidal masses.

The structures have only rarely been seen at autopsies but according to Bachrach have been seen on suprapubic cystotomy. He considers them to be closely allied to cutaneous angeiomata.

Berliner describes a profuse bladder hæmorrhage, in a girl aged eleven, which was found cystoscopically to be due to tumour-like elevations of bluish-red colour scattered over the mucous membrane.

Three cases are described in which death resulted from hæmorrhage, and these angeiomata were found post-mortem.

Bachrach's own case in 1909 is closely similar to that which forms the subject of this paper. A girl, aged 13, had had periodical attacks of profuse hæmaturia, lasting for some days, since she was four years old, and for a year these attacks were regarded as menstrual in origin, and ergotin was given. She eventually complained of lumbar pain and frequency of micturition.

On the outer side of the right thigh there was a large nævus and the veins of the right leg were inclined at times to swell. Cystoscopic examination showed at the neck of the bladder dilated varices and in the left half of the upper quadrant of the mucous membrane a blood-clot, about the size of a pea, from which blood must have come.

The cases he considers as congenital diseases of the bladder associated in most instances with congenital abnormalities of vessels elsewhere.

Treatment seems best to be directed towards arresting the bleeding by rest in bed and adrenalin-lavage, but if compelled to operate, Mr. Rowlands considers that it is best to use the thermo-cautery after supra-pubic cystotomy, as suggested by Mr. Symonds.

No authorities hitherto have mentioned the existence of phleboliths in these angeiomata, or suggested the likelihood of their occurrence and in this respect the case may be considered unique.

REFERENCES.

1. Hertzhr: "A Treatise on Tumours," 1912.
2. Bachrach: "Folia Urologica," 1910, iv. 101.

The Landon Out-Patient Tea.

REPORT FOR 1913.

The Landon Out-Patient Tea was held on December 25th, 1913. Six hundred and seventy children were invited and entertained, all expenses being paid out of the Landon Tea Fund. The tea itself was entirely successful, and the extra outlay on provisions appeared to have been fully justified.

The Niggers were, as usual, enthusiastically received. The success of the afternoon was unfortunately marred by the failure of the cinematograph show, which gave cause for considerable disappointment on the part of guests and organizers alike, and also added to the impatience of the children during the distribution of presents from the trees. Happily, however, there were no serious consequences. Seeing that the cinematograph show is now, for various reasons, excluded from future entertainments, it becomes necessary to consider seriously the question of a suitable alternative. Something in the nature of a minstrel or short variety entertainment might, perhaps, be given a trial.

The Secretaries would recommend, in spite of the very excellent organization on this occasion (as instanced by the additional notification of fire exits, the instruction of the police in regard to their duties, and the posting of extra stewards at all the doors), that further steps be taken to check the rush for the Christmas tree which takes place at the end of the entertainment.

There was a larger number of generous donations this year, in addition to the annual presentation in kind, and the collection made by hospital workers, and more particularly by the Dental Department and the Nurses' Institute, were especially commendable. Among the donors were Mrs. and Miss Landon. Letters of thanks have been sent to donors.

A. SEABROOKE,
J. A. RYLE, } Hon. Secs.

BALANCE SHEET.

Statement of Receipts and Expenditure.

Receipts.	£	s.	d.
To Balance brought forward from last Account	16	7	2
„ Donations, Collections, &c.	95	9	0
	£111	16	2

Expenditure.	£	s.	d.
By Cost of Tea (Caterers' Account) ...	27	0	0
„ Groceries, Provisions, Fruit, &c. ...	17	6	7
„ Clothing	11	16	0
„ Toys	16	9	9
„ Entertainment	1	0	0
„ Decorations	1	1	0
„ Printing, Stationery and Postage ...	3	2	6
„ Police Fees, Gratuities, &c.	2	10	0
	80	5	10
„ *Balance carried forward* :— Cash at Bankers	31	10	4
	£111	16	2

Audited.—C. H. WELLS.

March 18th, 1914.

Literary Intelligence.

Professor W. M. Bayliss has in preparation a new book, entitled, "Principles of General Physiology," which will be published by Messrs. Longmans & Co. The work will treat of the fundamental properties of animal and vegetable cells and organisms, somewhat on the lines of the "Phénomènes de la Vie," of Cl. Bernard. Special attention will be given to phenomena whose laws are not usually to be found in similar books, such as those of reactions in colloidal systems, oxidation, action on surfaces, as well as to secretion, excitation, inhibition, nutrition, and other more strictly "vital" processes.

Messrs. Longmans & Co. are proposing to issue a series of monographs on Physiology, under the editorship of Professor E. H. Starling, F.R.S., dealing especially with those parts of the science in which at the present time research is most active and progress of knowledge most rapid. Each monograph will be entrusted to an author, who himself is taking or has taken a leading part in determining the current ideas of physiologists on his topic, and it is intended that each volume shall give an account, not only of the present state of knowledge on the subject treated of, but also of the direction and tendencies of contemporary research.

The size of the volumes will vary from 100 to 300 pages. The following monographs are in preparation:—The Involuntary Nervous System, by Walter Holbrook Gaskell, M.A., M.D., F.R.S.; The Physiology ef Reflex Action, by Charles Scott Sherrington, M.A., M.D., F.R.S., F.R.C.P.; The Conduction of the Nervous Impulse, by Keith Lucas, M.A., F.R.S.; The Physiological Basis of the Action of Drugs, by H. H. Dale, M.D.; The Secretion of Urine, by Arthur R. Cushny, M.A., M.D., F.R.S.; The Contraction of Voluntary Muscle, by W. M. Fletcher, M.A., M.D.; The Cerebral Mechanisms of Speech, by F. W. Mott, M.D., F.R.S., F.R.C.P.; The Chemical Mechanisms of Integration in the Animal Body, by Ernest H. Starling, M.D., D.Sc., F.R.S., F.R.C.P.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Lectures on Medical Electricity to Nurses. By J. Delpratt Harris. (London: H. K. Lewis.) Price 2s. 6d. net.

Dr. Delpratt Harris has endeavoured to put into book form his lectures to nurses on medical electricity. As lectures his work must have been of certain interest to his listeners, most of whom had probably passed some time at the practical work of his electrical department. But for nurses who "may be seeking employment in the electrical department of a hospital, or undertaking the treatment of a private patient under the supervision of a medical man," *i.e.*, nurses who would be entirely ignorant of the rudiments of electrical treatment, Dr. Delpratt Harris's book is hardly one to be recommended —that is if they desire to understand electrical apparatus so as to be able to use it intelligently,

In the first chapters he makes use of terms, which to beginners are unfamiliar and, therefore, useless, for although they may be explained later in the book, it is impossible to pass on to higher points if the intermediate points are not consecutively explained and thoroughly understood. Such work is like teaching a child compound long division before it has learnt addition and substraction.

The chapter on ionisation is very inadequate for intelligent administration. Details of the treatment, especially in the case of the Finsen Lamp, are set down with very little explanation of the why and the wherefore. "Wrinkles" are added at the end of the book—"wrinkles" which for the most part are points of great importance, and would have been better added to the chapters to which they refer.

A nurse who takes an intelligent interest in her work would prefer a book which explained, in a more satisfactory manner, the treatments she is ordered to administer.

Alimentary Toxicæmia: Its Sources, Consequences and Treatment. (From the *Proceedings of the Royal Society of Medicine*, 1913, vol. vi.) (London: Longmans, Green & Co., 1913.) Price 4s. 6d. net.

This volume represents the report of the discussion held by the Royal Society of Medicine last year. The subject is one which has, as is well known, been attracting more and more interest of late years, largely owing to the work of Guy's men, and especially of Sir Arbuthnot Lane. All the chief protagonists in the controversies took part in the discussion, which was really a complete symposium of current views.

All the material in the present book has already appeared in the Proceedings of the Royal Society of Medicine, but has been now collected into one volume

of handy size and easy of reference. Many of the theories put forward will be rejected by most readers; each one will reject most of the views, and pin his faith to this or that definite solution of the problems, but no one, we imagine, will fail to find his own pet theory supported or attacked in the multitude of opinions gathered together. To those alike who have or have not a private opinion upon the subject we tender the same advice: read at least the more important contributions to this discussion if you wish to become familiar with the current views on this problem.

A Manual of Medical Treatment, in two volumes. By J. Burney Yeo. Fifth Edition. (London: Cassell & Co., Ltd.) Price, 25s. net.

It is now over four years since the last edition of Dr. Yeo's book was published. The appearance of a fifth edition is amply justified by the changes and advances that have taken place in medical treatment since 1909. The work of revision has been entirely in the hands of Dr. Raymond Crawfurd and Dr. Buzzard, the former being responsible for all the sections, except that on nervous diseases. While the general scheme of the book remains much the same as before, the revision has been thorough and the work has been brought well up to date.

The chief objection that we have to urge against the book is that the author and its editors tend to adopt far too an impartial tone. Mention is made of most forms of treatment, but only too often is the reader left to choose from these without a guide. To the recently qualified man—and it is he who is most in need of a book on treatment—this is a great disadvantage. He would find a rather more dogmatic style to be of greater service.

In other respects we can highly recommend this manual. The short description of the ætiology, pathology and symptoms which precedes that of its treatment is of great value. To anyone who is intending to purchase a book on treatment we can recommend this one with the greatest confidence.

The good printing and arrangement, and the small bulk make it a most serviceable book to use.

Practical Nursing. By Miss Stewart and Herbert Cuff, M.D. (Wm. Blackwood & Sons, Ltd.) Price 5s. net.

This is a new and revised edition of the well-known text-book on "Practical Nursing" originally written by the late Miss Isla Stewart, Matron of St. Bartholomew's Hospital, and Mr. Herbert Cuff, M.D., F.R.C.S., at present Principal Medical Officer to the Metropolitan Asylums Board.

The book has now been brought up-to-date by Mr. H. E. Cuff and Mr. W. T. Gordon Pugh, M.D., B.S., Medical Superintendent, Queen Mary's Hospital for Children, Carshalton, Surrey; the latter, who was associated with the production of the first edition, has greatly added to the value of the last, by the addition of a number of useful illustrations.

Of the original work little need be said, as it has long been regarded by those members of the nursing profession most competent to judge as one of the best of its kind on the market. In praise of the latest edition one can hardly say too much; not only is it so exceedingly well indexed that one can find with a minimum of bother and delay the point sought, but the result is so satisfactory that, having gained the desired knowledge, one wants to pass on to other subjects no less absorbing and interesting.

Of course, the chief value of the book lies in its being so thoroughly up-to-date, special chapters being devoted to instruction on such subjects as a few years ago were not thought so necessary for nurses as they are now.

Among others are chapters on the following:—The Treatment of Disease by Vaccines; The Finsen Method of Light Treatment; The Use of X-rays; New Growths. These and many other modern methods of treatment are described in such a manner as will prove an unending source of pleasure and satisfaction to nurses keen on their work, for are we not all familiar with the feeling of disappointment experienced when, on searching for information on such subjects as these, we find either that all our text-books are out-of-date and no mention is made of them or else that they are dealt with so briefly that we are little benefited for our pains.

Two of the most interesting chapters are those dealing with Infant Feeding and the Nursing of Sick Children; the former is illustrated by several instructive food and weight charts, and the latter shows the writer to have possessed such a thorough and detailed knowledge of child-life and nature both in health and disease as must make many who read feel that they have surely spent the greater part of their lives with their eyes but half open.

We have neither time nor room to mention here the numerous other points of interest in the fourth edition of "Practical Nursing," suffice it to say that not only beginners, but those well advanced in the nursing profession, could do worse than procure a copy. Its only apparent fault lies in its binding, for all will agree that it is a pity so much valuable information should be enclosed between such palpably cheap covers. However, one can only suppose that this is due to the fact that it is published at a popular price.

Anatomy: Descriptive and Applied. By Henry Gray, F.R.S. Eighteenth edition. Edited by Robert Howden. (London: Longmans, Green & Co., 1913.) Price 32s. net.

This latest edition of "Gray," of course maintains its position as probably the best text-book of anatomy for students which has as yet appeared. Indeed it seems unlikely that its proud position will ever be usurped. Other text-books have appeared, each with many individual excellencies and special sections which

were superior to "Gray," but they have none of them achieved in the same degree its completeness and at the same time its compactness. The striking feature about "Gray" is that whilst the whole subject is presented in one volume of comparatively moderate size, it is so clearly and concisely written that no section appears to be cramped, and nowhere has form or grammar been sacrificed to afford room for more fact. It is, indeed, a great example of value of using words in their true and exact sense.

The present volume does not differ in its essentials from the last, but men brought up on the older editions would find themselves sadly at sea owing to the use of the new or B.N.A. terminology. We are not concerned here to enter into the pros and cons of the controversy at present raging around the whole question of the adoption of the new terms; the question will no doubt be settled one way or the other in the course of a few years. Meanwhile it is sufficient to say that the descriptions in this edition are just as clear and just as true as ever in spite of the change of names.

The other changes that appear are chiefly those of re-arrangement, and are, we think, decided improvements. This especially applies to the collection of all the paragraphs on Surface Anatomy hitherto scattered throughout the book into one complete chapter. This will greatly facilitate reference.

We would humbly suggest yet another change in future editions, and that is, that the paragraphs on Applied Anatomy which appear in small print at the end of the descriptions of various structures be omitted. They are, we feel sure, quite valueless to men in their pre-clinical days, and later the same facts can be obtained more readily from medical and surgical text-books.

The illustrations follow the modern tendency in being less complex, more æsthetically coloured, and more clearly reproduced. Many new and excellent drawings have been added, those illustrating the capsules of the larger joints being especially good.

We have also received—Peristalsis of the Large Intestine, by Alfred C. Jordan, M.D., M.R.C.P.; The Surgical Work at Berck-Plage, by S. W. Daw, F.R.C.S.; The Clinical Report of the General Lying-in Hospital, York Road, Lambeth, for the year 1912; The University of Colorado Studies, November, 1913; Alimentary Enzymes in Theory and Application (Benger's Food, Ltd.); Electro-Pathology and Therapeutics, by Arthur E. Baines and F. H. Bowman, D.Sc. (London: Ewart, Seymour & Co., Ltd.) Price 5s. net.

Appointment.

Edmond, J. A., M.B., B.S., to Lambeth Infirmary, Brook Street, Kennington.

Rugby Football.

GUY'S v. NEWTON ABBOT.

For the second year in succession the Hospital team went to Newton (March 14th) to find the playing pitch almost under water. In fact, torrents of rain fell throughout the game, accompanied by a gale of wind. Guy's started well, and notwithstanding the weather conditions handled the ball splendidly, but Newton gained the first try which was led up to by good work on the part of the home forwards, West being the try-getter. No goal was added, and no better fortune awaited the second try of the homeside got by Mills, who was almost in directly on resuming, but he failed to hold a pass from Passmore. Before half-time Newton added two more tries. The wet and slippery ball made place kicking very difficult. Not a single try was converted.

Half-time was called with 12 points to nothing against us. We tried to pull up these arrears, but nothing came off, except one solitary try, to which Newton replied with another. It was a relief to all when the referee's "no side" whistle brought the game to a close. Final score: Newton Abbot, 5 tries, 15 points; Guy's, 1 try, 3 points. Team:—

Guy's.—H. Millett (back); S. S. L. Steyn, J. P. Jones, A. H. Harkness, C. L. Curle (three-quarters); L. R. Broster, C. H. Medlock (halves); A. S. Liebson, A. B. Danby, O. Parry-Jones, C. H. Laver, B. Laver, G. Monk, C. Pearce, F. J. Ordish (forwards).

GUY'S A v. ROYAL NAVAL COLLEGE.
Kent Cup Semi-Final.

Having played a draw at Greenwich ten days previously, the replay took place at Honor Oak Park on March 14th. It was terribly heavy going, and the rain-laden clouds fairly let go their contents after half-time, which, with a gale of wind, made things very unpleasant. For all that, though, it was a grand match, and a great pity that more Guy's supporters did not brave the elements to cheer their side on. Those sportsmen who did, witnessed a splendid match which reflected great credit on both teams. Most of the first half was hard scrimmaging, a very sticky turf and slippery ball compelling the players to use their feet and not their hands. Near the line both sides picked up, but the tackling was deadly, with one exception. The Guy's men did not mark Devas thoroughly enough. Twice it seemed the College must score through Williams, but McEvedy brought off two splendid tackles, and at half-time the score sheet was blank.

Changing ends, Guy's had the storm full in their faces, but they had no time to get cold as the College forwards set up a very hot attack, and our men had all they could do to defend. Parry-Jones, Shellswell, Anthony, Monk, and the rest struggled

bravely; Hopson also was pluckiness itself at the scrum base; all the other members of the back division defended without hesitation. They were up against a heavy and well-trained side. At last the defence failed. In a line-out, right by the corner, a forward got the ball and fell over the line with it for an unpreventable try. No goal followed. Right well did the Guy's men set to work to get on terms. Mackenzie ran almost as though it were a dry day. The forwards, with Day-Lewis up, bullocked their way. Now and again the backs tried handling. Once a good bout of passing saw Crook drop Day-Lewis's final pass. Then, with a minute to go, Mackenzie received near half-way. He ran in most determined fashion, warded off a couple of tacklers, and grounded over the line for a fine try. No conversion followed. The whistle went for "no side." The teams now played two more ten-minute periods, but no score resulted, and the game ended in a draw of 3 points each. Team :—

GUY'S.—P. F. McEvedy (back); A. M. Crook, A. K. Day-Lewis, N. Kendall, R. Mackenzie (three-quarters); A. F. Rook, M. S. Hopson (halves); O. Parry-Jones, A. L. Anthony, H. P. Whitworth, G. Monk, R. B. Munday, W. Gie, J. Shellswell, L. Muir-Smith (forwards).

REMARKS.—If these Guy's reserves finally win the Kent Cup it will be due to their splendid grit. A finer uphill game has never been seen at Honor Oak Park. Imagine the conditions and then fancy yourself 3 points down, giving away weight, and knowing full well that each man opposed to you is a fully-trained man. Day-Lewis knew all this, but he kept his side going splendidly, and they responded in a fashion that was magnificent. It is scarcely fair to single out players for special praise, but McEvedy's tackling, Day-Lewis's judicious touch-finding, Hopson's plucky exhibition, Rook's general soundness, Mackenzie's splendid play, and the good forward work of Parry-Jones, Anthony, and Shellswell, also the line-out work of Monk, deserve, perhaps, to be brought into special prominence.

GUY'S A v. ROYAL NAVAL COLLEGE.

KENT CUP SEMI-FINAL.

For the third time these sides met, on Saturday, March 21st, to decide who should pass on into the Final. This match was played at Greenwich, and fortunately for players and spectators alike the afternoon kept very fine. The ground in Greenwich Park has a deep layer of gravel beneath, consequently the surface is always dry, and thus the conditions for a fast game were promising.

To begin at the end, we were defeated by 1 goal 1 try to nothing. Penned up to their own 25 for some time, the College had to defend, but Guy's during this period sought touch too often instead of going for the line. The latter would have been more profitable. At length the Navy men got going, and, handling well, Syfret cut out a fine opening for Empson to score. Bennett goaled. McEvedy was next very prominent with some fine defensive work. Rook next came into the picture with a dribble right down the field, but he was very poorly supported, a like remark being applicable when Mackenzie ran characteristically down the left.

The half-time score was 1 goal against us. With determination the Guy's men set about pulling down the score, but except for a couple of runs by Mackenzie, who looked a scorer all over the last time he got away, and a break away by Crook, who finished his effort by punting into the Navy full-back's hands, nothing on our part looked really hopeful. The men tried their utmost, especially Hopson, Rook, Day-Lewis, and Mackenzie. Anthony, Munday, and Shellswell were the pick of the forwards. Monk often got the ball from the line-out, but he was not allowed to do much with it. Just at the end, the College were awarded another try. No conversion followed, the final score standing as above. Team :—

GUY'S.—P. McEvedy (back); R. Mackenzie, A. K. Day-Lewis, N. Kendall, R. Crook (three-quarters); M. S. Hopson, A. F. Rook (halves); L. Horsley, A. L. Anthony, H. P. Whitworth, J. Shellswell, R. B. Munday, G. Monk, W. Gie, A. Baxter (forwards).

REMARKS.—The "A" team are much to be congratulated on the gallant fight they have made to go so far in this competition. A. K. Day-Lewis has a fine team under his captaincy, and it is very comforting indeed to know such capable reserves are at the Hospital's command when needed. Many of them deserve a trial for the First XV., and no doubt many will be carefully watched when next season commences.

Change of Address.

Dr. John H. Jones, to Public Health Department, Queen Street, Melbourne, Victoria, Australia.

G. B. Pritchard, L.R.C.P., M.R.C.S., L.D.S., from Guy's Hospital, to 48, Queen Anne Street, Cavendish Square, W. (*Telephone*, Mayfair 2712.)

G. Maxted, Esq., M.D., B.S., from 58, St. Stephen's Road to 14, Thorpe Mansions, Norwich.

T. R. Trounce, M.R.C.S., L.R.C.P., to Royal Surrey County Hospital, Guilford, Surrey.

Births.

MALLESON.—On March 5th, at 30, Thurlow Road, Hampstead, N.W., to Mr. and Mrs. H. C. Malleson, a daughter.

MOLLISON.—On the 17th inst., at 26, Nevern Mansions, the wife of W. M. Mollison, M.A., M.C., of a son.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE publish in this issue with much pleasure a letter from the Rev. A. E. Popham, Acting Chaplain to the Hospital, on the subject of cases of attempted suicide. The problem of the after-care of these cases is a very important, but at the same time a very difficult, one, and we welcome the evidence afforded by Mr. Popham's letter of his courageous attempt to deal with those cases which pass through the wards. We wish him every success in his endeavours, and feel sure that he may confidently count upon the cordial co-operation of all the hospital workers. The difficulties in the way of giving these unfortunate individuals a fresh start are partly, perhaps chiefly, due to the abnormal mental condition of the patient, but also to a large extent to the attitude adopted by the public in general, and the law in particular, to them. The reasons which impel an individual to take his life are many and complex, but in the vast majority of instances they are, however logical and cogent, not sufficiently strong to make a normal man take a plunge so terrifying in its uncertainty. In a few cases a convinced atheist may argue that the outlook was so black that any method of escape was preferable to a life of almost certain misery, but speaking generally the patients attempt to kill themselves for reasons totally inadequate from the point of view of the average or normal man. At the bottom of most cases of suicide some disorder of the mental state is present, so that the patients have an abnormal view of their relation to their environment. The act of self-destruction is in fact an outcome, in many cases the logical end-result, of this alteration in the patient's mental outlook. Therefore any rational treatment of a case of attempted suicide only begins when the physical injuries have been healed, and is chiefly directed to obtaining a clear insight into the psychology of each patient. Unfortunately it is just at this stage that the hospital, and the hospital in this particular is a true mirror of the medical profession as a whole, washes its hands of the whole affair and turns the unfortunate individual over to the mercy of his own disordered mind, and to the terrible charity of the law and the public.

Unquestionably some definite arrangements should be made for the proper after-care of these patients. This is admitted on all sides, but meanwhile nothing is done if we except the invaluable work carried on here and there by individuals and societies. The cases come within the province of the morbid psychologist, and one or other of the two professions, the clerical and the medical, that dabble in that science, should definitely and systematically treat them. Neither profession has any profound knowledge of the subject, but the clerical at the moment at least have prior claim, both because they have always attempted to deal

with the subject in one way or another and at the present time are the only body who show any real enthusiasm in its prosecution.

The difficulties of the situation are not, however, surmounted when the patient is cured. Whilst his act was the result of an altered or abnormal outlook on life, that very act has now caused a definite alteration in his environment by making his abnormality obvious to his fellow men. It is a natural tendency among men to shrink from and avoid whatever they do not understand, and this phenomenon is especially marked in the case of would-be suicides. Their friends and relatives look askance at them with mingled feelings of fear and pity. The unfortunate man, already probably supersensitive by nature quickly becomes aware of the alteration in those around him, and is more than ever confirmed in his original misinterpretation of his future. Nor is this change confined to his immediate friends; he almost inevitably loses his employment, and finds that the story of his madness dogs his footsteps, preventing him time and again from obtaining fresh work elsewhere. We heard recently of a case in point: a man, for reasons unconnected with his employment, attempted unsuccessfully to take his life. On recovering from the effects of his injury he obtained through a good samaritan a new billet under a fresh employer. His original employer, however, thought it incumbent upon him, for reasons which we do not know, to inform the man's new firm of his recent act. He was, in consequence, discharged. It is clear, therefore, that not only must the individual be treated but, as is appearing more forcibly each day in every branch of the art of healing, the public must also be educated in the true significance of the lesser mental disorders.

There is yet another aspect of this question which is worth considering, and that is the attitude of the law towards attempted suicide. It is in England a felony, punishable by imprisonment, to attempt self-destruction. The logical result is, of course, that it is better from the point of view of the individual to make no mistake than to fail in the attempt. That is, in other words, a premium is put upon successful suicide. Of course, when the law was established it was accompanied by dreadful penalties wreaked on the body of the unfortunate man, and upon the goods of his family. These penalties, although we believe never repealed, are always in fact avoided by a merciful jury's refusal to bring in a verdict of *felo-de-se*. The penalties upon the unfortunate failure are still in a number of cases exacted, although, happily, a more enlightened and merciful view is spreading, and magistrates are less and less willing to send the prisoners for trial, preferring to put them under the wing of some individual who promises to give them a helping-hand.

The justification for this law was simple when the relations between Church and State were much more intimate than they are at present. In those days the State frequently undertook the punishment of spiritual crimes, under which heading suicide and attempted suicide were of course included. At the present day such a justification is no longer possible, and those who uphold the law are accustomed to fall back upon the argument that since the individual belongs to the community he commits a crime against the State by attempting to end his life. On the face of it this view is obviously one evolved to support an existing condition of affairs and would never be seriously considered for the purposes of constructive statesmanship. We feel strongly that all the laws dealing with the punishment of attempted suicides are an anachronism, and should be taken off the Statute Book as soon as possible. They are only harmful in their effects, serving to maintain and intensify the prejudices already existing against the unfortunate sufferers.

We have to congratulate Mr. F. C. Hunôt very heartily on his success in heading the list at the recent Entrance Examination for the Royal Naval Medical Service. It is worthy of note that at the last examination for the Navy a Guy's man, Mr. A. M. Henry, also obtained first place.

Dr. Frank Shufflebotham, who is so well known as an authority upon industrial diseases, has kindly consented to give a course of lectures in the School next month upon different aspects of industrial medicine. The subject is one of very great importance, especially in the large manufacturing districts, and requires much special study and research for its elucidation. In the Borough we do not meet with many cases of disease directly traceable to occupation save a few sporadic instances of lead poisoning and "trade eczemas," but in many districts of England the characteristic industry of the neighbourhood produces numerous cases of occupation disease, and it is important for all of us to have some idea of the class of symptoms which may be associated with particular industries. Many such diseases have already been recognized and to some extent minimized, but in all probability further research will add yet further to the list.

The syllabus for the course is as follows:—

Lecture I. Symptoms and diagnosis of Lead-poisoning.

Lecture II. Post-mortem appearances of Lead-poisoning.

Lecture III. Miner's Nystagmus (with a demonstration on living cases).

Lecture IV. Industrial fibrosis of the Lung.

Lecture V. Anthrax.

Lecture VI. The Medical Aspect of the Workmen's Compensation Act.

The Lectures will be given on Fridays at 4 p.m., commencing on May the 8th. It is confidently hoped that there will be a large attendance of men throughout the series. Of course, it goes without saying, that all old Guy's men will be welcome to attend the series.

We note with much pleasure that Mr. F. J. Steward is one of the candidates for election to the Council in July next. There are almost a dozen candidates for three vacancies, so that the competition is very keen, and we hear that canvassing has already commenced. As is well known, Mr. Steward's great abilities as a member of committees would make him a very valuable acquisition to the Council both from the point of view of the College and also of the School. We wish him every success in his candidature.

We have already referred in these colums to the Smoking Concert which the Residents are holding in the College this month. Dr. A. Allport will take the chair, and a large number of well-known entertainers have already promised their support, so the function will certainly be a great success. The date selected is April 30th, the Residents' "Going-off" day. The price of the tickets will be 2/- each, and they may be obtained from any of the Residents or from the President, Mr. W. Robinson. All Guy's men, both past and present, are cordially invited and are promised a very enjoyable evening.

We would remind *all* Guy's men that this is the year of the Biennial Dinner, and impress upon them the necessity of making a note now of the time and date so that as many as possible may be able to put in an appearance. The Dinner of 1912 constituted a record in point of numbers, more than 300 being present, and it is confidently expected that this year the record will be beaten once more. There are some Guy's men who have never been to a Biennial Dinner, and many who have not attended for several years. We can promise all these a very enjoyable evening, meeting their old friends and contemporaries, many of whom probably they have not seen since they left the hospital. The arrangements whereby the three toasts of "The King," "Guy's Hospital and School," and "The Chairman," are given without any speeches, have been so popular and successful at the last two dinners that they will be continued this year.

The date fixed for the dinner is Friday, July 3rd. Sir Cooper Perry has kindly consented to preside, and the Connaught Rooms have been again engaged. The price of the tickets will be 10/6 each, exclusive of wines, and the diners will be seated at small tables, each with a Vice-President.

We would impress on every Guy's man the fact that the success of the dinner is largely dependent on the exertions of each one. If they will do all they can to help by writing to, and looking up, their old friends and inducing them to come, the dinner will certainly be a great social success.

Ralph Wingent Memorial Fund.

FOURTH LIST OF SUBSCRIPTIONS.

	£	s.	d.
Willie W. Cook, West Hartlepool	1	1	0
Arthur H. Crook, Eastbourne	1	1	0
G. Frank Hardy, Dulwich	0	10	0
W. Norman May, Sonning	0	10	6
C. H. Reinhold, I.M.S., Bijnor, U.P. India	1	1	0
J. G. Saner	0	5	0
	4	8	6
Previously acknowledged (March 10th, 1914)	19	3	6
Total	£23	12	0

H. C. MANN,
P. S. PRICE,
Hon. Secs.

April 6th, 1914.

Pupils' Physical Society.

A Pathological Meeting of the Society was held in the Wills Library on Thursday, March 19th, Mr. N. Garrard in the chair. Thirty-two members were present.

Dr. Nicholson demonstrated the method of obtaining frozen microscopical sections of tissues by the use of solid CO_2.

Mr. C. P. Symonds showed a piece of irregular bone removed during a laparotomy from a cicatrix in the substance of the abdominal wall. Dr. Nicholson compared it to the bone that is occasionally laid down in old tuberculous foci, and said that the formation of bone was only the last of a series of changes which fibroblastic tissue was capable of undergoing.

Mr. A. Seabrooke showed a specimen of hypernephroma removed at an autopsy after death from other causes. Mr. Seabrooke stated that there were two theories of the origin of these tumours, ascribing them respectively to renal and suprarenal sources. He favoured the latter, since the cells of the tumour, like the suprarenal cortex but no other similar tissue, contained a doubly-refractile fat.

Mr. C. H. Edwards described a case of actinomycosis occurring in a corn merchant. The primary source had been the iliac bone, where healing had taken place, but direct extension had occurred to the wall of the chest on the same side, and from there the lung had become infected.

Dr. Ryffel showed a specimen of a small white kidney. The confusion in the classification of chronic kidney disease, he said, arises from the uncertainty of the history and the insidiousness of the course. Kidneys of this, the "Rose Bradford" type, commence probably in a slight and unsuspected acute nephritis. One variety of renal insufficiency manifests itself by œdema from a failure to excrete chlorides; another variety, by some other failure of function, leads to a gradual raising of the blood-pressure. The kidney disease is progressive in this type, and leads to gradual replacement of the renal tubules by fibrous tissue, and to death from uræmia. Fibrosis of a kidney is the effect, not the cause of atrophy of the tubules.

Mr. G. S. B. Long described a specimen of a fibroid heart from a case of sudden death, due, as Mr. Long pointed out, directly to syphilis. There was an aneurysm of the left ventricle, which had very nearly perforated.

Mr. J. A. Ryle described the organs from a case of tabes mesenterica. The trachea, cæcum, and ileum showed widespread tuberculous ulceration. In the case of the trachea, though the tracheitis was general and many ulcers were present, the larynx appeared normal and the vocal cords were not involved.

Mr. W. R. Reynell had a case of infective endocarditis with an abscess in the liver, embolus of the middle cerebral artery with cerebral softening, and infarcts in the spleen, kidney, and heart muscle. Mr. Reynell suggested that these emboli in the coronary arteries explained two sudden attacks of intense dyspnœa, which were noted during the last two days of the patient's life. Dr. Ryffel emphasized the difference between the nature and significance of dyspnœa and hyperpnœa. The latter, characterized by a low alveolar CO_2 value, could not be due purely to circulatory or respiratory difficulty, and suggested some other factor, such as uræmia. In true dyspnœa, such as Mr. Reynell's case, the CO_2 would be high, for the disorder was purely of circulatory origin.

The final meeting of the session was held on Saturday, March 28th, in the College Smoking Room, Mr. F. J. Steward in the chair. There was a good attendance of members, 45 being present. The following gentlemen were nominated as Presidents of the Society, and declared elected:—

F. Bevan-Brown, B. Burnside, E. J. Cooke, C. Dean, A. H. Harkness, W. M. Lansdale, A. S. Liebson, S. Long, C. E. Petley, C. P. Symonds.

The Committee's awards of the Society's prizes for the year were announced to be as follows:—For the

best paper read to the Society (£10), Mr. W. M. Lansdale, for his paper on "Locomotor Ataxy and other parasyphilitic affections." For showing most interesting cases and specimens, not awarded. For taking most active part in discussions (£2 10s.), Mr. A. H. Harkness.

Mr. Steward, who had kindly acted as judge in the competition for the Treasurer's Prize Essay, then announced that he had awarded it to "Omean." This essay was found to have been sent in by Mr. J. Stephenson. The subject was "Surgical Shock." Mr. Steward congratulated Mr. Stephenson on his excellent work, and called on him to read it to the Society.

An interesting discussion followed, in which the Chairman, Messrs. Ryle, Miller, Eagleton, Pedley, Ogilvy, Harkness, Dr. Shipway, and the Hon. Secs. took part. On the motion of Mr. A. Seabrooke a vote of thanks to Mr. Steward for taking the chair was carried unanimously, and the Society adjourned till next October.

On looking back over the past session of this, the oldest Medical Society in London, one cannot feel that members of the Hospital, and especially the students, have been supporting it as well as they used to, or as well as it deserves. This is reflected in the fact that the Committee were unable to award all their prizes this year. Students are showing an increasing reluctance to take active part in the meetings. It is usually possible to induce a fair number to be present if one can guarantee them an interesting selection of cases or specimens; and in the standard of the exhibits, and in the actual numerical attendance the past season has probably not been much below standard. But from the point of view of intelligent discussion, or rather discussion at all, for that is all that is asked, there has been a very lamentable falling-off. Students will not get up and show their ignorance. They prefer to listen to the few senior men who happen to be present. "Perhaps Dr. So-and-so could explain this, or suggest that," is the constant demand. The difficulty is a real one. Dr. So-and-so probably knows a great deal more about the subject than his questioner, and so, if that were the point at issue, would be the best qualified to speak about it.

But the real object of these meetings is not at all to pick the brains of the experts. It is the exact opposite, and the Society would achieve its object far more efficiently were there no experts there, if in their absence the junior men could be persuaded to think questions out for themselves and give their own views upon them. It is so difficult to make people realise what in the light of experience is almost self-evident, that the only stimulus to thought is speech, and that thought, independent thought, is the one thing that can make intelligent men of us, and lead to progress, either in medical science or in human character.

On a lower plane of reasoning it is perhaps worth while to point out, that the Society offers prizes of sufficient value at least to keep a microscope out of the pawnshop, or to buy quite a number of music-hall stalls. Men who have recently come into the wards, or are hoping soon to come into the wards, are most earnestly urged, for their own sakes and in their own interests, to show a keen and active interest in the Society's programme for next season.

Pass List.

University of London.

Second Examination for Medical Degrees: Part I. March, 1914.

Organic and Applied Chemistry.

Caldecott, Francis.	Howe, Joseph C. C.
Deacon, Edwin Frank.	Leblanc, Felix Raoul.
Elkington, Guy Waterwan.	Lindsay, Gordon Parmiter.
Fitzgerald, Gerald Hartas.	Pritchett, Henry Norman.
Gill, Lawrence.	Traill, Kenneth Robert.
Hinde, Eric Clark.	Wong, Sik To.

Young, Frank.

Second Examination for Medical Degrees: Part II. March, 1914.

Bensted, Harold John.	Sampson, Basil.
Gray, Hugh Morgan.	Vance, Wm. John.
Kyle, James.	Wacher, Herbert Stewart.
Leviseur, Herbert John.	Wallis, Morris John Theodore.
Lloyd, Vernon Edmund.	
Nicholls, Wm. Howard.	

Conjoint Board.

At the First Professional Examination of the Conjoint Board, held on March 24th, 25th, 26th, 27th, and 28th, the following candidates were approved in the undermentioned subjects:—

Chemistry.—Guy Meadows, George Augustus Skelmerdine Shacklock, Cecil George Douglas Siggs, Arthur Arnold Osman, Ian Murray Thomson, Bertie Moorwood Tonkin.

Physics.—Harvey James, John Nesbitt Martin, George Bertram Monk (D.D.S. Michigan), Michigan and Guy's Hospital.

Biology.—Hector Demetrius Apergis, Frederick Knowles Escritt, Wyndham Brooks Farrington, Robert John Hodgkinson, George Bertram Monk (D.D.S.), Edward Hugh Frederick Morris, George Augustus Skelmerdine Shacklock, Graham McKim Thomas, Roger Gilbert Wilshere.

A Case of Salvarsan Poisoning.

S. W., male, æt. 23, was admitted on March 13th in an unconscious condition. On Tuesday, February 24th, patient was admitted into St. Mary's Hospital suffering from syphilis, apparently of quite recent origin. The Wassermann reaction was found to be positive. Patient was detained at St. Mary's for a night, and was given an intravenous injection of salvarsan (·6 gramme). He felt no ill-effects as the result of this, and a fortnight later, Tuesday, March 10th, was again admitted for a night and a similar dose was administered.

This second dose occasioned a considerable reaction, the temperature rising to 102° after a rigor, but the patient was well enough to return home on the Wednesday, and though feeling very dull and heavy went to his work as clerk in an office on the Thursday. He went home early, had no appetite, and was sick, but went to the office again on the Friday. He fell as he entered the building, and was so dazed and stupid all the morning that his employer about midday sent him with the office-boy in a taxi-cab to see a City doctor. On the way he had a fit with twitching of the limbs and foaming at the mouth, and was brought straight to this hospital by the police.

On admission patient was quite unconscious and very irritable to external stimuli. The pupils were markedly dilated and reacted sluggishly to light, while the patient moved his arms in a peculiar waving manner and had occasional spasmodic struggling attacks.

He was a well-developed young man, and presented no external abnormalities. The pulse, which was of good volume, was 108, the temperature 100°, and the respiration 36. Lungs and heart appeared to be normal, while there was the merest trace of albumen in the urine.

Lumbar puncture was at once performed, and about 40 c.c. of perfectly clear cerebro-spinal fluid drawn off under considerable pressure. This gave considerable relief, improving the force and volume of the pulse and relieving the spasms, which were now frequent and violent in character.

A typical spasm would start with a horizontal nystagmus followed by clonic contractions, first of the facial muscles, then of the arm, and finally of the trunk and leg muscles. The spasms never became tonic in character. Between the spasms the purposeless waving of the arms never ceased.

Towards night the lungs became full of moist sounds, and atropine was administered. Chloral was also given, and when the spasms were very violent, chloroform was administered. Most relief, however, was given by lumbar puncture, and this was repeated at intervals of two or three hours throughout the night and during the following morning. The fluid always gushed out under considerable pressure, and in all nearly three-quarters of a pint were drawn off. This fluid contained no cells, was quite clear, and gave a positive Wassermann reaction. There was no optic neuritis, and by midnight the pupils had returned to a normal size. The temperature gradually rose, and by the Saturday morning was 105°, the pulse being 120, and very feeble and irregular. Patient remained in this unconscious condition with frequently recurring spasms until 3.30 p.m., when he vomited a large quantity of black blood and died.

At the post-mortem examination no evidence of syphilis was found either externally or in any of the internal organs. The brain weighed 1580 grams; there was an extreme degree of bright-red injection of the vessels in the pia arachnoid, and the grey matter was also of a pinkish hue from hyperæmia; there was no meningitis, however, and nowhere were any hæmorrhages to be found.

The lungs presented no pneumonia, pleurisy, or pleuritic adhesions. They were, however, remarkable for the large number of diffuse hæmorrhages scattered through the lung substance, similar hæmorrhages being present also beneath the pleura and even in the mediastinum. There was blood-stained, frothy sputum in the big tubes. The bronchial glands were not enlarged. Beneath the visceral layer of the pericardium were three or four petechial hæmorrhages. Heart arteries and arterioles were normal.

There were submucous hæmorrhages in the œsophagus and a few submucous ecchymoses at the fundus of the stomach. The kidneys and other organs were perfectly normal. In the liver $\frac{3}{4}$ gr. arsenic was discovered; in the spleen, 1/100 gr.; and in the two kidneys, 1/60 gr.

The case is interesting in that it raises the question as to how long a patient should be kept at rest and under observation after an intravenous dose of salvarsan; and also as to the length of time which should be allowed to elapse between two such injections.

Change of Address.

C. D. Killpack, M.B., B.S. Lond., from Bromham Road, Bedford, to Sydney Road, Haywards Heath, Sussex.

Dr. A. H. Godson, from 63, Union Street West, Oldham, to Oak Bank, Windsor Road, Oldham.

G. R. Hind, M.B., B.S., from 20, Stamer Street, to 2, Brook Street, Stoke-on-Trent.

T. Morland Smith, M.R.C.S., from Heron Court House, Charminster Road, Bournemouth, to "The Hive, Exeter Road, Bournemouth.

Some Common Forms of Cardiac Irregularity.

CLINICAL LECTURE BY Dr. HUNT.

Gentlemen,—I am taking Cardiac Irregularity as the subject of my lecture to-day, partly because I am so impressed with the importance of recognizing its true significance, and partly because the literature on the subject deals with its theoretical aspect rather than with its application to practical medicine.

One of the most striking advances in medicine during recent years has been the increase of our knowledge of the physiological and pathological conditions affecting the regularity of the heart-beat. The foundation of research in this department was laid by Dr. James Mackenzie, and although a few of his original hypotheses have since been disproved, his book will always testify to his eminence as an accurate scientist and careful clinical observer.

Ten years ago very few successful attempts were made to differentiate between the different types of irregular pulse. It was recognized that irregularity often occurred in association with the more serious forms of cardiac failure, and consequently this sign was always viewed with anxiety, or at least suspicion, when it was discovered either in patients who presented other signs of heart disease, or in those who showed no other evidence of myocardial trouble. The consequence was, that patients were often unnecessarily alarmed, were debarred from various forms of exercise and enjoyment, and made to undergo a coarse of treatment for a heart lesion of little or no significance.

Now, although it was only in 1908 that the first edition of Dr. Mackenzie's book was published, describing the mechanism by which these alterations in the nature of the pulse were produced, so much additional work has been done since then on the subject that we are now in a position to estimate with a fair degree of accuracy the significance of any type of irregularity and to prescribe our treatment accordingly.

I wish to indicate to you in this and my succeeding lectures the sequence of events in the heart which causes the different forms of irregularity, the means—clinical and graphic—by which they may be recognized, their ætiology, and, finally, their prognosis and treatment. It is inevitable that I should call your attention to certain theoretical considerations in speaking of means of diagnosis, but I shall deal with this part of the subject as briefly as possible, and devote more time to the purely clinical side of the question, particularly that of prognosis and treatment.

I hope to show you that there are certain forms of irregularity which indicate the presence of grave myocardial mischief, which entail the most cautious treatment and limitation of the patient's activity, whereas others do not denote any serious morbid change in the heart, and are no contra-indication to the severest forms of muscular exertion. If I can convince you of this I shall be able to refute the accusation so often levelled at cardiac research, that the recent work is merely of academic interest, has no clinical importance, and has proved to be of no service whatever in the treatment of diseases of the heart.

I intend to consider to-day two common forms of cardiac irregularity, but before proceeding to discuss them I must remind you of some points in connection with the mechanism of the healthy heart. In the normally acting heart the auricles contract first, and their contraction is followed in rather less than one-fifth of a second by that of the ventricles. This sequence depends on anatomical conditions; the heart's contraction originates in a mass of neuro-muscular tissue, known as the sino-auricular node, which is situated in the right auricle close to entrance of the superior vena cava; from here conducting fibres pass through the auricle, cross the auriculo-ventricular junction, and terminate in the muscle of the ventricles. The auricles are dependent on the sino-auricular node for the stimulus which causes their contraction, and in the same way the ventricles contract in response to the stimulus which has previously affected the auricles. If the anatomical connections between auricles and ventricles are intact, the

rate of both these chambers will be determined by the rate at which impulses are discharged from the sino-auricular node, and this node is, therefore, sometimes spoken of as the "pace maker" of the heart.

Two methods are used for recording graphically the movements of the auricles and ventricles. In the first, simultaneous records are taken of the radial and jugular pulses by means of Mackenzie's polygraph; in the second, the electrical changes associated with the contraction of the heart are recorded by means of the electro-cardiograph of Einthoven.

ventricle; the intra-auricular pressure falls and there is a corresponding fall in the "v" wave; the summit of the "v" wave therefore coincides with the point at which the auriculo-ventricular valves open.

The jugular pulse curves therefore give us important information with regard to the time relations of the contraction of the auricles and ventricles. (Fig. 1.)

The electro-cardiograph registers the electrical changes which are associated with the contraction of the auricles and ventricles. The galvanometer used consists of a conducting

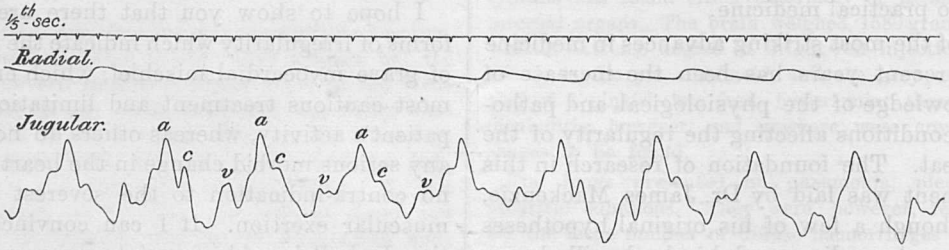

Fig. 1.—Radial and jugular pulses in a normal subject: "a" is the auricular; "c" the carotid; and "v" the ventricular wave.

The venous pulse curves.—In taking the venous pulse the tambour is placed over the jugular vein and the carotid artery, just above the right or left sterno-clavicular junction, and records are obtained of the changes of pressure in the right auricle, and of the change of volume of the carotid artery. In the normal subject three waves appear during each cardiac cycle. The first wave is caused by the rise of intra-auricular pressure due to the contraction of the auricles and is known as the "a" wave; the second is due to the expansion of the carotid artery and is almost synchronous with the beginning of ventricular systole, it is known as the "c" or carotid wave. The third known as the "v" or ventricular wave also occurs during systole. Its explanation is as follows: While the ventricles are contracting the auriculo-ventricular valves are closed and the auricles are being filled with blood; this flow of blood into the auricles raises the intra-auricular pressure, and the rise is responsible for the "v" wave. As soon as the auriculo-ventricular valves open the blood flows from auricle to

fibre which lies in a magnetic field, and any current which passes through this fibre causes it to deflect and take up a new position. The heart's current is passed through this fibre by connecting the patient's right arm and left leg to the two ends by means of wires and suitable electrodes. The movements of the fibre are photographed on a moving plate and thus graphic records are obtained.

Three waves are found in the normal electro-cardiogram; the first is associated with auricular contraction and is known in Einthoven's nomenclature as the summit "P"; the second and third are associated with ventricular contraction, the former being a pointed peak known as R, the latter a blunter peak known as T. (Fig. 2.)

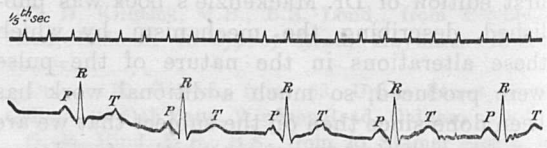

Fig. 2.—Electro-cardiogram of a normal subject: P is the auricular wave; R. & T. the two ventricular waves.

Sinus irregularity.—It has already been pointed out that the rhythm of the heart depends partly on the rate and regularity with which impulses are discharged from the sino-auricular node. Irregularity in stimulus production arising here is spoken of as sinus irregularity, and will affect both auricles and ventricles in similar fashion, *i.e.*, the time relations between auricular and ventricular contraction will remain unaltered, each ventricular contraction being preceded by an auricular in the ordinary way. Irregularity of this nature occurs very frequently in healthy persons, and is nearly always influenced by respiration, the pulse becoming faster during inspiration and slower during expiration. For this reason it is generally easy to recognize the condition clinically (Fig. 3). In some cases, however, the difference in the intervals between successive heart-beats is so great (particularly in children), that some form of myocardial disease may be suspected (indeed I have known it simulate heart block very closely), but in any case of doubt graphic records, by showing that the normal auriculo-ventricular sequence is undisturbed, will make the diagnosis clear. It is very important to recognize sinus irregularity, and to avoid mistaking it for any pathological condition; it must be considered purely physiological, and not indicative of any damage to the heart muscle old or recent; its presence therefore does not in any way influence the treatment and prognosis of any illness rheumatic or otherwise.

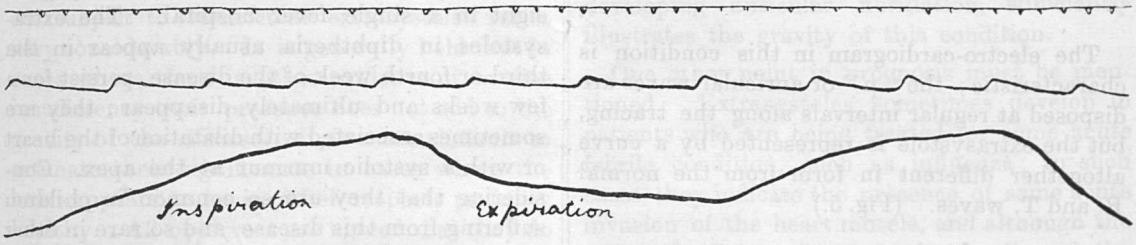

Fig. 3.—Respiration and radial pulse curves showing that the pulse becomes faster during inspiration and slower during expiration.

The second form of irregularity which I wish to consider is known as the ventricular extrasystole. I have pointed out to you that the heart's contraction starts at the sino-auricular node under normal conditions; but power of originating a contraction lies in all parts of the heart muscle, and it sometimes happens that the normal rhythm is interrupted by a premature contraction or extrasystole, which starts in one or other of the ventricles, and which follows closely upon a normal beat.

If you consider the effect of this extrasystole on the radial pulse you will realize that it will vary according as the premature beat occurs late or early in diastole. In the former case sufficient time has elapsed for the ventricle to be almost filled, so that sufficient blood is forced into the aorta for the expansion of the radial artery to be felt; this beat, however, will be of smaller volume than the one preceding it; following this smaller beat there will be a pause* rather longer than the interval between two normal beats. If, however, the extrasystole occurs early in diastole the ventricle will contain very little blood and the expansion of the radial artery will be very much less; indeed, it is frequently so small that the premature beat is not perceptible at the wrist. The pause in this case will be much longer, and if the pulse is felt it will seem to the observer that the heart has missed a beat altogether. This constitutes one of the forms of intermittent pulse.

This form of arrhythmia may be more easily diagnosed by an examination of the apex. On palpation the extrasystole and the succeeding pause are readily recognized; on auscultation the extrasystole is represented by a first sound following closely upon a normal first and second sound.

In jugular tracings the auricular rhythm is seen to be undisturbed, "a" waves succeeding

* This pause is due to the fact that the auricular contraction following the extrasystole is not followed by a contraction of the ventricle.

each other at regular intervals; the extrasystole is represented by a small carotid wave which occurs just after the "v" wave, the succeeding "a" wave not being followed by a carotid wave. (Fig. 4.)

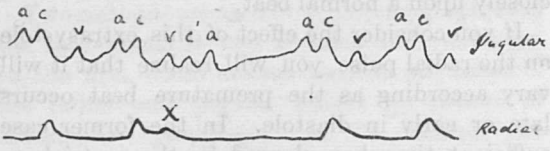

Fig. 4.—Radial and jugular pulses showing an extrasystole at X following the second normal beat. The extrasystole is represented by a small beat on the radial pulse followed by a long pause. Corresponding to the small beat in the radial is a carotid wave c. The succeeding auricular wave is not followed by any carotid wave since it evokes no ventricular contraction.

The electro-cardiogram in this condition is characteristic; the "p" or auricular waves are disposed at regular intervals along the tracing, but the extrasystole is represented by a curve altogether different in form from the normal R. and T. waves. (Fig. 5.)

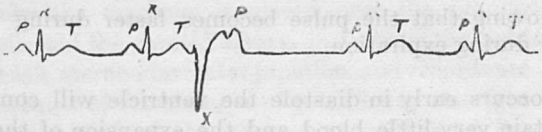

Fig. 5.—An Electro-cardiogram showing an extrasystole at X following the second normal beat. The form of the abnormal ventricular waves is quite different from that of the preceding normal ones. The auricular wave P. which follows the extrasystole causes no ventricular contraction.

Occasionally the electro-cardiograph is the only means whereby a diagnosis of extrasystoles can be made, for it may happen that the extrasystole produces no wave in the radial pulse, and that the patient has a thick chest wall through which it is difficult to hear the heart sounds; and, further, it is often impossible to obtain legible jugular tracings.

Ætiology.—Ventricular extrasystoles occur in a very large number of different conditions, which may be divided into two main groups:—

A. A group in which there are other signs of heart disease.

B. A group in which the heart appears to be otherwise normal.

Group A.—This includes, first, cases of myocardial degeneration due to fatty or fibroid change in the heart muscle. Secondly, cases of rheumatic heart disease; although it should be added that in rheumatic cases extrasystoles are not very common. Thirdly, extrasystoles sometimes develop in patients suffering from one of the specific fevers. This is particularly the case in diphtheria, and the fact is of interest in view of the common teaching that extrasystoles rarely occur in children, and are almost unknown under ten years of age. In the course of a few months, however, I found this type of irregularity present in at least a dozen children all under the age of eight in a single fever hospital. The extrasystoles in diphtheria usually appear in the third or fourth week of the disease, persist for a few weeks and ultimately disappear; they are sometimes associated with dilatation of the heart or with a systolic murmur at the apex. Considering that they are so common in children suffering from this disease, and so rare in other conditions, I am inclined to regard their presence in a child as evidence of a previous attack of diphtheria. Extrasystoles occasionally develop during an attack of influenza; their presence has not been recorded in typhoid or scarlet fever. Fourthly, they are often associated with dilatation of the heart secondary to overstrain, the so-called athletic heart.

In the second group (*B.*) their causation is often obscure, but I am sure that two factors in their production are dyspepsia and excessive smoking (possibly that is the reason why they are so common among students here) for I have often noticed that they disappear when the dyspepsia is treated or the consumption of tobacco diminished.

Symptoms.—Patients in whom extrasystoles are associated with organic heart disease usually present themselves at hospital complaining of the ordinary cardiac symptoms: dyspnœa, œdema, etc., but those whose hearts are otherwise healthy often complain of the symptoms due to the irregularity alone. A

common history is as follows:—The patient may have had a tiring day's work, comes home and eats a dinner rather larger than usual, which is followed by two or three extra pipes or cigarettes. He goes to bed, but is awakened after a short sleep by a feeling of palpitation or the sensation that his heart is stopping. This latter symptom is, of course, due to the long pause following the extrasystole. If he has studied medicine he feels his pulse, and noticing its intermittent character, is alarmed, remembering cases of serious cardiac failure he has seen associated with an irregular pulse. The mental anxiety thus produced is one of the most troublesome symptoms of this condition, and is one of the important features to remember in treatment and prognosis.

Prognosis.—The prognosis of patients who are subject to ventricular extrasystoles varies very considerably. It is generally held that in cases where there is other evidence of cardiac insufficiency their presence does not add to the gravity of the disease. It is more difficult to estimate their significance in cases where the heart appears to be in other respects perfectly healthy. All observers are agreed that they do not point to any serious lesion, and that no great restrictions need be imposed, provided that there is no other sign of heart disease, and no symptom of cardiac failure. There is, however considerable difference of opinion as to the exact amount of muscular exertion that should be permitted. Are we justified in allowing men with extrasystoles to do laborious work, or to row, and play such games as football, which impose a very considerable strain on the heart? I have met with a fair number of such cases, particularly in students at the hospital, and have never seen any harm result from vigorous exercise provided that "training" has been thorough.

The three following cases illustrate this: The first is a man who has been known to have extrasystoles for the last three or four years, and has been in the habit of running the quarter-mile. The second is one whose pulse was first noticed to be irregular about three years ago, and who subsequently trained and played football for the greater part of a season; a point of considerable interest in his case was that after "training" his pulse became perfectly regular. The third is a man who has done a good deal of mountaineering during the past two years. I have examined all these patients recently; their hearts are of normal size, the sounds are clear, their pulse rate about 70; they have all been completely free from any cardiac symptoms, and apparently the exercise they have taken has in no way damaged their hearts. The great importance of a correct diagnosis of extrasystoles will be obvious if we compare their prognosis with that of two other common forms of irregularity, viz., heart block and auricular fibrillation; the former is always a sign of serious myocardial damage, and its presence prohibits any form of severe exertion, while the fact that patients rarely live ten years after developing auricular fibrillation, sufficiently illustrates the gravity of this condition.

One other point in prognosis must be mentioned. Extrasystoles sometimes develop in patients who are being treated for some acute febrile condition, such as influenza; in such cases they indicate the presence of some acute invasion of the heart muscle, and although the focus of inflammation may be small, and the lesion trifling in extent, it is certainly safer to keep such patients at rest for a longer period than usual, in view of the fact that the cardiac infection is of recent origin.

Treatment.—This varies considerably in different cases and is determined more by the presence of other signs of heart disease than by the nature of the irregularity itself. If there are signs of cardiac failure the usual treatment for this condition should be followed. If the heart is otherwise healthy we should endeavour to find the cause of the extrasystoles and treat any associated dyspepsia, and limit smoking if it is excessive.

Sufficient has been said under the heading of prognosis to indicate the amount of exercise that should be allowed.

If the patient complains of irregular action of the heart and particularly if he is alarmed by it, it is most essential to point out that the condition is of no serious significance and to assure him that, in spite of anything he may think to

the contrary, the long pause following the extrasystole does not mean that his heart is soon going to stop beating altogether. It is really necessary to do this, for patients who are conscious of extrasystoles often suffer from considerable distress and anxiety under the impression that they have some serious form of heart disease.

With regard to drugs remember that digitalis is quite useless for the irregularity alone; indeed I have seen it increase the frequency of extrasystoles and thereby aggravate the symptoms; it should only be given if there are other signs that indicate its administration. Here, again, we may compare the effect of digitalis in this condition with its action in heart block and auricular fibrillation; in the former case it should always be given with caution, because of its tendency to increase the degree of heart block, whereas it is an almost specific remedy for the latter, being indicated in nearly all cases, even in the absence of cardiac failure.

Bromides, however, are of undoubted value, partly because they act as sedatives and partly because they seem to have a direct effect in diminishing the frequency of the premature beats.

Appointments.

House Physicians.—Messrs. A. C. Clifford (Dr. Hale White); A. J. Eagleton (Sir Cooper Perry).

House Surgeons.—Messrs. E. S. Taylor (Sir Alfred Fripp); H. W. Evans (Mr. Steward).

Out-Patient Officers.—Messrs. C. H. Gould, E. D. Scott, H. C. Rook, W. H. Ogilvie.

Assistant House Surgeons.—Messrs. C. Sherris (Mr. Fagge); J. F. Venables (Mr. Rowlands); F. Bevan-Brown (Mr. Turner); E. W. Blake (Mr. Hughes); P. H. Berry (Mr. Davies-Colley).

Clinical Assistants.—Messrs. T. I. Bennett (Orthopædic and Genito-Urinary); G. Marshall (Neurological).

Gazette Special Pathologist.

F. A. L.—In the absence of any details of this material, we believe it to be a fibrous epulis. It shows dense fibrous connective tissue and inflammatory changes, covered by thickened mucous membrane. Foci of calcification are seen here and there. We find no evidence of a malignant growth.

PATHOLOGIST.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Sir, - Will you allow me to appeal for information and suggestions in an enquiry of some public interest? The Fabian Research Department, in continuing its study of insurance, is now investigating the working of industrial life assurance (the widespread system of canvassing households to insure their children's lives), and the provision of funeral benefit by friendly societies, co-operative societies, clubs, and trade unions, together with the system of compensation for accidents, now so generally made a matter for insurance by employers.

We want to know the good effects, and the bad, of the canvassing system, which makes industrial insurance so costly.

We want to know whether the insured persons always get what is due to them, and if not, on what grounds is payment refused.

We want to know the good effects, and the bad, of insuring babies' lives, and whether there is now any injurious "gambling in lives."

We want to know about the lapsed policies—why they lapse, who profits by their lapse and who loses, and what surrender value or fully paid up policy is given to the policy-holder in exchange for the lapsed policy.

We want to know why millions of poor people prefer the expensive policies of the companies to the cheaper policies of the post office.

We want to know how the co-operative insurance works, under which every store member finds himself and his wife automatically insured, in proportion to their purchases, without having to pay any weekly pennies at all.

I should be grateful of any account of personal experience, or any description of how these things are working, and for any suggestions for their improvement. A full list of points for enquiry will be sent on application.—I am, Sir, yours faithfully,

SIDNEY WEBB.

Fabian Research Department,
37, Norfolk Street,
Strand, W.C.
April 3rd, 1914.

Dear Sir,—In the Gazette of December 7th, 1912, Mr. J. Ryle, the then Editor, as the result of a conversation with me, wrote, "our attention has recently been directed to the existence of a definite need for reform in the treatment of a certain small class of patients admitted to the Hospital, *i.e.*, attempted suicides." As

you know we get a certain number of these cases, some of which are charged at the police courts, and some not, and I have tried during the past two years to give them a helping hand, getting work and lodgings, and making myself responsible to the Magistrate for them. But one's duties as Chaplain are so many that one has really no time for extra work. I am leaving the Hospital shortly, but do not wish to give up this part of the work, and with the approval of Sir Cooper Perry, and the Chaplain who succeeds me, the Rev. G. Charlesworth, I am continuing this care of suicides. May I, through your columns, ask the co-operation of the House Officers and Sisters, when cases of this description come, to let me know, that I may visit them and do what I can to help. A note or message to the College of St. Saviour will always find me.

The College of St. Saviour,
9, St. Thomas's Street,
Southwark, S.E.
April 6th, 1914.

Yours truly,
A. E. POPHAM,
Acting Chaplain.

Notices.

Junior Guyite Club.

A Dinner of the above Club will be held on May 14th, at the Restaurant Frascati (Alpha Salon), 7.30. R. M. H. Randell, Esq., in the chair; A. E. Price, Esq., Vice-Chairman. Price of dinner, 7s. 6d. (Wine not included). Members are requested to answer before May 10th.

Western Lodge,
Romford.
JAMES A. FRASER,
Hon. Secretary.

Guy's Hospital.

MEDICAL SCHOOL PRIZES, 1914.

Golding-Bird Gold Medal and Scholarship in Bacteriology.—Mr. W. A. Young, Scholarship; Mr. W. E. Tanner, Certificate (proxime accessit).

Michael Harris Prize for Anatomy.—Mr. L. S. Debenham, Prize £10.

Wooldridge Memorial Prize for Physiology.—Mr. L. S. Debenham, Prize £10.

Junior Prizes for General Proficiency.—Mr. L. A. Debenham, Prize £20; Mr. G. E. L. Simons, Prize £15; Mr. J. Joffe, Prize £10.

DENTAL SCHOOL PRIZES, 1913—1914.

Prize in General Subjects for Second Year's Students.—Mr. M. G. Whitten, Prize £10; Mr. F. E. Welton, Certificate; Mr. D. Clewer, Certificate.

Prize in Dental Subjects for Second Year's Students.—Mr. D. Clewer, Prize £10; Mr. M. G. Whitten, Certificate.

Prize in Dental Subjects for First Year's Students.—Mr. G. A. Pennant, Prize £10.

Through Andorra.

II.

It appears to be the custom for the cowherds of the Jasse de Tresbregades to get up at five in the morning, even the good example we set by staying in bed had no effect on them, and for the next hour our sleep was disturbed by the cowbells of the cattle ascending the valley.

When at six we set about preparing breakfast we found the Asten Valley filled with drifting mist, which at times hid the snow which had fallen on the opposite mountains during the night. But we knew that sunshine would be found across the frontier, and at nine o'clock we set out for the pass. After travelling through wet woods for half an hour we came to an open, rocky spot where we found our Catalan friend. He stood on a big rock, and leaned on his staff glaring up the wet valley; a sack on his shoulders gave him little protection but his wooden shoes certainly were more water-tight than our alpagartas.

Mournfully he begged us to wait another twenty-four hours until he could accompany us to Salden in Andorra; we pretended regret, but in reality his offer increased our resolution to push on, for we knew that walking at his pace would very quickly kill us.

As we would not wait, he came with us for a mile, striding along at a speed that was dreadful to us; every now and then he would once more tell us exactly how the track went, and indeed we were careful to follow his directions minutely, for the track got more and more obscure, and beautiful as is the French ordnance map it is very difficult to identify mountains when one is in steep valleys. He left us at a point where for once the track is well marked; it goes along a high cliff, an iron railing has been put up to help the giddy traveller, for the Asten here runs two hundred feet below one.

We were now above the forest, it was bitterly cold, the wind coming straight down from the high mountains near the passes. There was no wood, but with some methylated spirit we were able to brew some tea, and, after gnawing a crust or two, we pushed on, crossing the Asten by a narrow plank bridge.

Another half hour brought us to what we recognized as the famous division of the river; it is here that the unwary go wrong, they take the tempting westerly track and are subsequently found at the foot of the Pic de l'Homme Mort. The mule-track had now completely disappeared and for several miles we steered by the compass; at last we came to a broad jasse where a large heard of cattle was grazing; the rain had started every little tributary of the river, and where our map showed one stream leading from the Lake of Feuntargente we found three streams coming from three different points of the compass. For a quarter of an hour we debated; at any time thick fog might come up and force us to return to the Tresbregades; at last we saw a herdsman with his dog high up the mountain side on our right,

we must ascend to him, and as we went up little tracks appeared from nowhere, ran together to form bigger tracks, then these two joined up, and in a short time we found ourselves on the mule track. We came to the old man, who, after a smoke and a drink, walked slowly up the mountain with us until we came to the crest and saw the Lake of Feuntargente.

It was here that the two adventurous Anglais, man and wife, had camped and fished and shot during the previous summer. The little lake stands almost at the summit of the mountains; even now, in midsummer, a big drift of snow lay on one side.

The old cowherd pointed our way and we left him: passing the lake on our left we turned to the east, and then sharply south along a rocky depression, where scratches on the boulders showed the track. A thick fog came down, but the wind was directly in our faces, and with an eye on the compass there could be no going astray now; and in a quarter of an hour we began to go downhill. Five minutes later we came suddenly into bright sunlight. It is an extraordinary thing to cross the Pyrenean frontier in this region; the whole environment changes in less than half a mile; here we stood in strong sunshine, the wind had gone, the rough broad rocks had gone, instead there were brown, steep, hill-sides with no trees, no signs of cattle or human life; and on our left a little stream gathered volume every minute —half an hour before we had been beside the Garonne, now we were by the Ebro.

If the track from France to the frontier is difficult to find, that from the frontier down into Andorra is certainly correspondingly easy. Our track had disappeared again, but there was no other way possible than between the easy slopes of brown mountains.

We came past empty stone barns; the loose stones were collected to form walls to empty fields, a horse could be seen in the valley, and at last we came to some men building a shed, and what seemed to be a water-wheel. And at evening we reached Salden, the first town; our Catalan friends had told us of the best resting-house, and we repeated the name they had told us, "Luzetête" it sounded like, until we found it.

Salden is a tiny place, I suppose there are fifty or a hundred people in it, but it shares the distinction of French and Catalan villages; you can get a clean bed, and a good meal in any of them. So here we met the famous pale wine, the Vin Rosée, of Andorra; pink it is, with a flavour reminiscent of port, and a potency which is lost on the unfortunate and immune native. There is a balcony to the Posada, and from it you may look down the widening valley that leads to the capital, or up the easterly valley which leads to a comparatively easy pass into France; but in this direction the traveller from the Feuntargente does not look, for it is by it that the occasional American discovers Andorra. And after food you may gather round the cauldron that hangs over the open fire in the kitchen, and with scraps of Spanish and French you may gossip with Madame (or is it Senora?) Luzetête.

It was here that we first were given raw smoked pig's-flesh; there is an extraordinarily long lean pig that alone of all edible creatures seems to flourish in these parts; it is accounted a great delicacy, "C'est de la montagne!" your hostess will announce when she brings it in. And brown bread and honey are also of the mountain, the honey being rather wonderful. There is something very subtle about honey; that West Indian honey that can be bought in red earthenware pots has always something exotic and tropical in its flavour; and the honey of Andorra is far more alluring than that. It has not, perhaps, the same air of freedom that pervades the smoked pig, but it carries a tantalising murmur of the South—one eats it, as it were, to the half-heard click of the castanets.

Bed, and sleep, and then bad black coffee and the road; for a real road begins at Salden, a rough effort that would not allow a cyclist, but still a road of sorts; at Encamps (pronounce it as you like) we lunched and bathed, the last performance causing some excitement, and then went on downhill.

As we descended we came to occasional fields of barley and oats, and a vineyard or two, but the land seemed to yield little, and the houses and villages were all brown and a trifle bare and monotonous like the mountains. And so we reached the capital, Andorra-the-Old, where once a year the Parliament meets (in the dining-room of the Inn where we stayed). There is a church and a store where you can buy picture post-cards and tea out of a bottle, and a post-office which is really a shoe-maker's shop. And it must not be assumed that because the stamps sold are French stamps, that the Andorrans are not a separate nation; the tribute of £100 that they pay to France is merely a proof of their practical nature, just as the fee of £50 that they pay the Bishop of Sev d'Urgel in Spain is an instance of their piety. In Andorra-the-Old one stays at the Posada Calonnes, and it comes as rather a shock when one learns that the young man who receives you is named Calonnes; it is as if one should walk into the Ritz, and the commissionaire should shout out "Ritz!" and immediately a smiling proprietor should advance.

But the Posada is cheap and clean, and comfortable enough for those who can stand dinner being two hours late. We met an American and his wife there, I do not like to speak of them, they had come by the lazy route, but the woman appeared to be rather a remarkable character; she could find nothing satisfactory in Andorra-the-Old; I shall never forget her great cry of disgust "there's not even a Cinema here!"

Literary Intelligence.

Her Majesty Queen Alexandra, whose great sympathy with all charitable objects is well known, has been graciously pleased to accept a copy of Dr. C. W. Hutt's work, "Hygiene for Health Visitors, School Nurses, and Social Workers," recently published by Messrs. P. S. King & Son.

Obituary.

BENJAMIN NEALE DALTON.

We regret to have to announce the death, on the 23rd March, of Dr. Benjamin Neale Dalton, late of South Norwood, at the age of 70.

Dr. Dalton had a distinguished career as a student at Guy's Hospital, and was a well-known, successful, and highly esteemed practitioner. He was born at Stockwell, and was educated at the City of London School, where he obtained a prize for Chemistry. He was then for a time at "Lloyds," but continued in the evening to work at Chemistry with the intention of studying for the Medical Profession at the earliest opportunity. This came in 1863, when he entered at Guy's Hospital, and soon made his mark. He took the First Prize for General Proficiency at the end of his first year, and the same at the end of his second year. At the end of his third year he again took the First Prize in all the subjects of the year's work, as well as the Treasurer's Gold Medal for Medicine, and the Treasurer's Gold Medal for Surgery. In the same session he was awarded a Prize of £10 by the Physical Society for a paper on "Malformations."

Naturally he filled all the usual appointments. He was dresser to Mr. John Hilton in 1867, and in the same year he obtained the qualifications of L.R.C.P. and M.R.C.S., and in 1868 was House Surgeon. Immediately after this he turned his attention to the University of London; he passed the Preliminary Scientific Examination in 1868, and the First M.B. (now called the second examination for medical degrees) in 1870. In the October of that year he joined the teaching Staff of the Medical School as Demonstrator of Anatomy, his colleagues in the dissecting-room being Mr. (now Sir Henry Howse), Mr. J. N. C. Davies-Colley, and Dr. F. Taylor. He held the office for two years, but in this interval he started the practice in Norwood which became his life's work, and he did not succeed to any other teaching appointment. But he added to his distinctions by taking in 1872 the Final M.B. London, with the Scholarship and Gold Medal in Medicine, and Honours in Obstetric Medicine and in Forensic Medicine. In those days the Scholarship in Medicine was of the value of fifty pounds a year for two years. In the following year, 1873, Dalton became Doctor of Medicine.

From this time he gradually acquired a large practice in South Norwood, and was widely known as a thoroughly sound and scientific practitioner. He was always deeply interested in the advanced work of his profession, was a constant attendant at the scientific meetings of the local branch of the British Medical Association, and contributed valuable and thoughtful papers for discussion from time to time. In the early days of his last long illness he showed to the writer, with justifiable satisfaction, the MS. of a paper read by him many years before, before the Divisional Meeting, in which he insisted on the infective characters, then hardly recognized, of rheumatic fever. He was a diligent student of the progress of medical science, kept himself *au courant* with all modern work, and made as far as possible his own clinical and bacteriological observations on blood, urine, or other secretions. He had a great love of reading, and was always ready to discuss with his friends questions of history, literature, and philosophy. His active hobbies were gardening, carpentry, photography, and, on his holidays, travel.

His illness, which commenced in the latter part of 1908, soon compelled him to relinquish practice; and after a time he was removed to London, where he spent the last two years of his life. He was married in 1878, and leaves a widow, three sons, and two daughters.

A Few Notes from General Practice.

During the past few weeks I have had two cases coming to me with a scrotal swelling, which in the first instance appeared to be simply hydroceles, but which subsequently proved to be secondary to malignant growths of the testicle. If one may judge from the text books this association of hydrocele with malignant disease is uncommon, being much more frequently met with in syphilitic disease of the testis.

The first case was a young man, aged 27. After the first tapping I noticed nothing wrong with the testicle, but the scrotum filled up again in a few days, and after the second tapping I found an irregular enlargement of the testis. The diagnosis seemed to lie between tubercular disease and sarcoma, but on watching the condition, and finding the swelling rapidly increasing, the latter appeared the more probable. My partner operated, and removed the testicle dividing the cord as high up as possible. The wound healed quickly, and for a few weeks everything seemed satisfactory, but there are now symptoms pointing to a recurrence in the lumbar glands. On microscopic examination the growth proved to be an embryoma.

The second case was in a man aged 40. Here, again the hydrocele was in evidence two or three weeks before anything was noticed wrong with the testicle, although in view of the previous case, I examined carefully. There was a considerable chance in this case of the trouble being syphilitic, so I put the patient on large doses of potassium iodide, but after two weeks he complained of shortness of breath, and on examining the lungs I found the physical signs of a widely-scattered broncho-pneumonia. The patient's condition rapidly became worse, and in a few weeks proved fatal. The growth turned out to be a soft carcinoma with numerous secondary growths in the lungs.

Attention has more than once been called to the danger of giving adrenalin chloride hypodermically to patients under an anæsthetic, but I have not seen a case recorded in which its administration to a patient not

under an anæsthetic has given rise to alarming symptoms. A few days ago I was called to a lady suffering from asthma. As she had been treated elsewhere with the liquid extract of the supra-renal gland given hypodermically, I injected 5 minims of 1 in 1,000 adrenalin chloride. I had not put the syringe away when the patient called out that she felt very ill; she complained of general throbbing, and an acute cramp-like pain at the heart and extending down the left arm. In fact, the symptoms were very suggestive of an anginal attack. She turned a corpse-like colour, was almost pulseless, and I thought she was going to die then and there, but to my great relief this alarming condition gradually passed, although it was an hour before she quite recovered. As 10 minims is an average dose, my experience with 5 minims may save others from running a similar risk.

A middle-aged lady developed jaundice with symptoms suggestive of gall-stones. On operating, my partner did not find any stones, nor was anything made out to explain the jaundice, so beyond draining the gall-bladder nothing was done. For several weeks the patient made no progress at all, she passed pale and particularly bulky motions, suffering constantly from flatulence and dyspeptic symptoms. Thinking the condition might be one of chronic pancreatitis, I put her on cachets with menthol, chloretone and bismuth, for the indigestion, and Fairchild's preparation of the pancreatic enzymes known as holadin; this was combined with bile salts. A most gratifying result followed, for in a few days she passed normal motions, the first for three months, and after three weeks continued improvement the patient is practically herself again.

J. A. B. HAMMOND.

A Case of Paralysis of the Inferior Division of the Third Nerve following Removal of the Anterior Portion of the Middle Turbinate.

This patient, a man of 36, was admitted into the hospital with the following history:—In the first week of November of last year he underwent an operation for the removal of the anterior portion of the middle turbinate. When he recovered from the anæsthetic he noticed that the lower lid of the right eye and face beneath it was black, that he saw double, and that the right eye was turned up and outwards. The first condition quickly cleared up.

On admission he had a divergent squint of the right eye, crossed diplopia, which increased to the left, there only being normal vision in the right upper part of the field. The movements of the eye were defective, the eye not moving inwards or downwards. The pupil of the right eye did not react to light either directly or consensually. The vision of both eyes separately was normal.

The diagnosis of paralysis of the inferior division of the third nerve was made, the lesion lying between the otic ganglion and the junction of the inferior with the superior division. The injury to the nerve must have taken place just after it had emerged from the sphenoidal fissure, being most likely due to damage to the ethmoidal cells and the orbital floor above them in removing the middle turbinate. B. B.

[I am indebted to Mr. Ormond for his permission to publish these notes.]

Papers by Guy's Men.

The Milroy Lectures on the Hygienic Aspect of the Coal Mining Industry in the United Kingdom. By Frank Shufflebotham, M.D., J.P. Lecture V. Beat Hand, Knee, Elbow, and Buttock.—*British Medical Journal*, April 4th, 1914.

M. S. Pembrey, M.D.: Physiological Observations upon Intratracheal Anæsthesia; Procs. Roy. Soc. Med.: Section of Anæsthetics, March, 34.

Case of Splenic Anæmia Treated by Splenectomy. By Herbert French, M.D., and Philip Turner, M.S.; Procs. Roy. Soc. Med., Clin. Section, March, 77.

G. N. Meachen, M.D., B.S.: A Case of Congenital Hairy Mole; Procs. Roy. Soc. Med., Dermat. Sect., March, 109.

F. Gilbert Scott: The Radiographic Appearances of the Sella Turcica, in Diseases of the Pituitary Gland.—Procs. Roy. Soc. Med., Electro-Therapeutical Sect., March, 58.

T. G. Stevens, M.D.: Uterine Fibroids; one impacted in the Pelvis Obstructing Delivery; Cæsarean Hysterectomy.—Procs. Roy. Soc. Med., Obstet. and Gynæcol. Sect., March.

T. G. Stevens, M.D.: Eclampsia.—Procs. Roy. Soc. Med., Obstet. and Gynæcol. Sect., March, 185.

W. M. Mollison, M.C., F.R.C.S.: Case of Left-sided Cerello-pontine Lesion, probably Tumour.—Procs. Roy. Soc. Med., Otol. Sec., March, 38.

Births.

SCOTT.—At The Mall, Wanstead, N.E., on March 4th, the wife of Philip Scott—a son.

TALFOURD JONES.—On March 31st, at 42, Craven Park, Harlesden, N.W., the wife of W. H. Talfourd Jones, M.R.C.S. Eng., L.R.C.P. Lond., a son.

Deaths.

HICKMAN.—On March 31st, at The Hollies, Wanstead, Herbert Brian, the dearly beloved and loving only son of Herbert Vigers and Alice Maude Hickman, aged 13 years 11 months. Though often in pain, always patient, loving, and thoughtful for others.

DALTON.—On March 23rd, at Hampstead, after over five year's illness, Benjamin Neale Dalton, M.D., late of Selhurst Park House, South Norwood, S.E., aged 70.

PURDOM.—On March 25th, 1914, Violet Elizabeth, age 33, wife of Dr. Percy Purdom, of Clevedon, Grove Road, Sutton.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 674.] APRIL 25, 1914. [SIXPENCE.

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Passim.

IT is an everyday experience at Out-Patients to see youths presenting themselves for examination because they have a varicocele. On enquiry the great majority of these men say that the condition causes them no trouble at all, or at most they complain of a slight dragging pain in the scrotum towards the end of the day. The usual story is, that they were unaware that anything was amiss until they were examined previous to admission to one or other of the services. They are then usually told that they will only be accepted if the varicocele is operated upon. As a result they come to a general hospital and are taken in for operation, filling a bed unnecessarily for a week or more.

We do not believe that the great majority of these cases need any operation at all. A varicocele rarely gives rise to sufficient symptoms to disable a patient even temporarily, and there are very many civilians with the condition who do work quite as severe as any army work without experiencing any appreciable trouble.

The authorities, however, have decided that they will not accept as a soldier anyone suffering from varicocele. Whether they take up this position because their experience leads them, in opposition to their civilian colleagues, to believe that a varicocele does give rise to sufficient trouble to prevent a man from doing his work efficiently or because they fear that its possession may form a suitable excuse for malingering, we do not know. Whatever the grounds upon which their objections are based, they are apparently willing to accept the man as soon as most of the dilated veins are removed, and consequently he very commonly comes straight from the recruiting officer to the hospital and asks to come in for operation.

It is difficult for the surgeon to refuse to operate upon such a case, however much he may disapprove of the operation, but on general grounds we think that some steps ought to be taken to prevent these cases coming into a general hospital. Most civilian surgeons are agreed that an operation is needless at best, even if it is harmless, and there is some evidence that, apart from immediate operative and post-operative risks, a certain proportion of the cases show a subsequent atrophy of the testicle on the same side. If, then, the army authorities are not content to follow the general opinion of the profession in this matter, we think they should not expect the preliminary treatment, which they require, to be carried out by voluntary hospitals. The surgical wards of general hospitals are already taxed to their utmost capacity, and have constantly a waiting list sufficient to fill all the beds more than twice over. Therefore, it does not appear to us to be fair that they should be expected to find valuable room for cases which do not, in the ordinary way, require treatment. The logical conclusion is, we believe, that if the military authorities are badly in need of recruits, as appears to be the case, they should take these cases into their own hospitals and treat them themselves.

The Musical Society will hold their second Choral and Orchestral Concert for the session on Friday, May 1st, at 8.15 p.m., in the Physiological Theatre. A very full and interesting programme has been prepared; the details appear elsewhere in this issue. The concert promises to be even better than the last, and it is hoped that the attendance will be largely increased next week. Anyone who was present at the last concert will agree that he was provided with a thoroughly enjoyable evening's entertainment, and will, we feel sure, come again on May 1st. He will also, we hope, induce his friends to come and so help to make the affair an even greater success.

We publish this week the balance sheet of the last concert. It will be seen that the Society's financial position is not so good now as before that concert, since the balance in hand has fallen from £6 to £1, and in addition the subscriptions from honorary members have already been received. The financial success of the concert, therefore, depends almost entirely upon the sale of tickets, and it behoves everyone who loves music to rally to the support of the Society and so ensure that the season does not end with a deficit.

In our last issue we inadvertently omitted to note that the list of house-appointments was a revised list, two of the gentlemen originally appointed having resigned through illness. Mr. L. B. Stringer, who had been made an O.P.O., was compelled to resign owing to a recurrence of trouble in an old focus in his lungs, and has gone away for a long voyage to the East to recuperate again. Mr. W. E. Tanner, who has been laid up in Clinical for some weeks past, had to resign his post of A.H.S. to Mr. Fagge. We sincerely condole with both gentlemen on their bad luck and wish them both a speedy recovery and early re-appearance among us.

Messrs. Stringer and Tanner furnish but two examples of a phenomenon which is constantly appearing in all large hospitals. There seems to be something particularly debilitating about the atmosphere of a hospital. Most men are able to resist it for a few years and whilst they do not actually live on the precincts of the hospital, but sooner or later practically every man succumbs and is laid up for a longer or shorter period. A large percentage of them catch one or other of the exanthemata, probably simply because they have such unusually good opportunities of coming into close contact with the cases in the Surgery and Out-Patients. But the other diseases cannot in most instances be ascribed to a direct infection, and must be explained rather on the view of a lowered resistance on the part of the individual. Whatever may be the reason for this predisposition we are convinced that there is only one real prophylactic, and that is change of air and scenery as often and as long as possible. Every house-officer ought, we believe, to go away for at least one week-end in every month, and if possible more often.

The Residents' "Smoker" will be held, as we have already stated, in the College Dining Room on Thursday, April 30th at 8.45 p.m. immediately following the "Going-off" Dinner. Dr. A. Allport will take the chair and a large number of well-known artistes have promised to appear. Among others, we note Mr. Chas. Capper who whistles so perfectly, Dr. Byrd Page, whose slight-of-hand is a constant source of wonder, Messrs. Cuthbertson, Ernest Hastings, Ben Nathan, G. Seabrooke, and several others, including several representatives of our own local talent. With so good a programme the evening is sure to be a great success, and, in fact, we hear that already the applications for tickets are sufficient to ensure a successful evening. Tickets, price 2s. each, may be obtained from any of the Residents or from the President, Mr. W. Robinson.

As a corollary to the appointment of a Lecturer in Pharmacology, it was decided that one of the clinical staff should give a course of lectures on Therapeutics during the summer term. It is a common complaint among men that so little time is devoted to teaching the principles and details of treatment and the course which, very appropriately Dr. Beddard is to give, should be greatly appreciated. The whole subject of

therapeutics is a complex but very interesting one and an attempt to deal with it systematically will, one imagines, help men to a better understanding of the reasons underlying the treatment of any given case. The complexity of treatment is after all more apparent than real, and the same broad principles underlie all the minor variations. The lectures will be given on Thursdays at 4 p.m.

We are asked to state that the lectures on Forensic Medicine will be given during the coming session on Mondays and Fridays at 4 p.m. On Mondays they will be held in the Anatomical Theatre and on Fridays in the Chemical.

The Nineties Club.

The Third Annual Dinner of the Nineties Club will be held at the Trocadero on Wednesday, May 6th, at 7.30 p.m. for 7.45 p.m. The chair will be taken by Dr. A. J. Cleveland (Norwich). Members are requested to inform either of the Hon. Secs. of their intention to be present, and of the number of their guests, if any, on or before Monday, May 4th.

PERCY HENRY, Esq., L.D.S.,
27, Nicholas Lane, E.C.
LAWRIE McGAVIN, Esq., F.R.C.S.,
32, Weymouth Street, W.
Hon. Secs.

Change of Address.

T. P. Berry, M.D., from 5, London Street, to "Coddrington," Westlecott Road, Swindon, Wilts.

Dr. Victor A. Luna, from Pacasmayo, Peru, to Apurimac 344, Lima.

M. Fred. Hopson, L.D.S., to Box 8, P.O., Queenstown, Cape Province, South Africa.

Lieut. G. Alan Blake, R.A.M.C., from Aldershot, to Station Hospital, Fyzabad, India.

Dr. C. H. D. Ralph, to Victoriaburg, Accra, Gold Coast.

A. Alan Forty, from 26, Park Square, to 24, Park Square, Leeds.

H. N. Purdom, Esq., L.D.S., to "Rosslyn," Albert Road, Clevedon.

F. G. Lloyd, M.R.C.S., L.R.C.P., from Queen Charlotte's Hospital, Marylebone Road, N.W., to c/o Mrs. Hudgston, 3, Spottiswoode Street, Edinburgh (till July 15th).

(*The Editor will be very glad to receive a postcard with notes of any change of address.*)

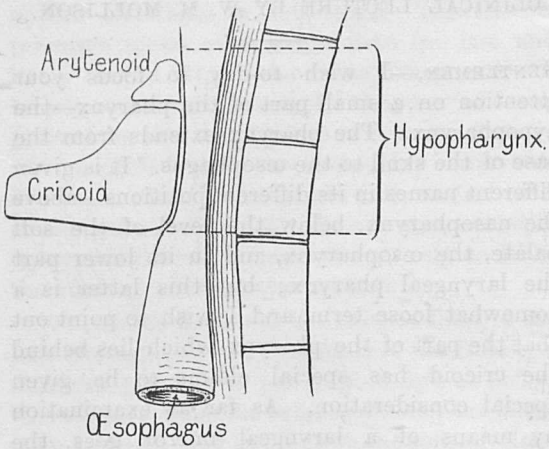
Carcinoma of the Hypopharynx.

CLINICAL LECTURE BY W. M. MOLLISON.

Gentlemen,—I wish to-day to focus your attention on a small part of the pharynx—the hypopharynx. The pharynx extends from the base of the skull to the œsophagus. It is given different names in its different positions—above the nasopharynx, below the level of the soft palate, the œsopharynx, and in its lower part the laryngeal pharynx; but this latter is a somewhat loose term, and I wish to point out that the part of the pharynx which lies behind the cricoid has special claims to be given special consideration. As far as examination by means of a laryngeal mirror goes, the lowest part of the pharynx lies on a level with the arytenoid cartilages, and has on either side a lateral recess, as it were; this lateral recess lies on the outer side of the aryteno-epiglottidean folds, and is called the pyriform fossa. Between this level and the beginning of the œsophagus is the part of the food tract which we are considering, and you will notice that the whole pharynx down to this level is an open tube and the passage is common to food and air, but below this the passage is a potential space only opening to allow the passage of food during deglutition. Further, the boundaries of this hypopharynx are more or less rigid; its anterior wall is the smooth expanded posterior aspect of the cricoid cartilage; its posterior wall is the pharyngeal wall resting on the vertebral column with its prevertebral ligaments, muscles, and fascia. Since the cervical vertebral column is convex forwards, this is another factor in the narrowing of this hypopharynx.

The sum of these considerations amounts to this, that the hypopharynx is the narrowest part of the pharynx and has comparatively rigid walls. It is to be observed that below the cricoid the œsophagus is an open tube. This fact is confirmed on examining the œsophagus with a Brüning's tube. The cricoid is the part

of the pharynx most difficult to pass, but once passed the tube does not have to push apart opposed mucous surfaces, but lies in an open space, and the observer is able to look into a constantly patent tube.



These anatomical facts have important bearing on the pathological conditions which obtain in this short part of the food tube. Mechanical obstruction occurs here, hence *foreign bodies* are apt to be held up: also *corrosive fluids* leading subsequently to stenosis. From the lowest part of the hypypharynx spring œsophageal *pouches*. Occasionally *ulcerations* occur here, too, these ulcers may arise as a result of long continued pressure in debilitated patients, as, for example, in typhoid; the patients lie for many weeks on their backs and the continued pressure between the back of the cricoid and the spine produces an ulcer. Syphilitic ulceration does occur also and will lead to stenosis subsequently. Wilks and Moxon describe two cases of stenosis at the "junction of the pharynx and œsophagus" due to previous ulceration, one obviously gummatous and one of unexplained origin.

This region is unfortunately often the site of *carcinoma;* the growth begins on the posterior surface of the cricoid and spreads on to the lateral wall and so to the posterior wall of the tube; the ulceration may pass down towards the œsophagus, and, indeed, frequently does so before giving any sign on laryngeal examination; it may and does pass upwards and forms large masses of growth overhanging the larynx and so obstructing the respiration, or at least changing the voice; and mechanically obstructing deglutition.

I have here several specimens from the Museum (512–520) all of this variety of carcinoma, and you will see how extensive the ulceration may be, as well as spreading as I have told you; you see it ulcerating into the trachea, invading the thyroid gland and giving rise to secondary deposits in the glands of the neck.

I have read you the short notes of the histories of the patients from whom the specimens were obtained; you will notice first that the patients are women, and not only so, but young women from twenty-four to forty-five years of age; the greatest age incidence is thirty-five to forty. You will notice that the cause of death is, as a rule, broncho-pneumonia, a result of inhaling the septic material from the surface of the growth as it overhangs the larynx; and lastly that their chief symptom is dysphagia. Pain is not a prominent feature.

A survey of these specimens gives you a good idea of the symptoms of these patients; the only one of importance to be added is salivation.

When a woman of 37 complains of difficulty in swallowing, has salivation, and is getting thinner, without any previous history to suggest stenosis from other causes, suspect carcinoma of the hypopharynx. Laryngeal examination may aid the diagnosis; there may be a mass of growth to be seen overhanging the larynx, in which case the diagnosis is clear; there may be no ulceration to be seen at all, but a suspicious sign is a collection of frothy mucus or saliva about the pyriform fossæ; this is due to unswallowed saliva which nests above the ulcer, which itself is just out of sight. The only certain method of diagnosis lies in examination of the hypopharynx by means of Brüning's tubes.

The treatment will depend on the stage of the growth when the patient comes under observation; unfortunately the growth so often has ulcerated extensively downwards before the patient is seen, and in this case treatment can only be palliative; the passage of a long tube

through the growth into the stomach for feeding. Should the case be seen early enough, operation may be undertaken with a fair chance of success, but at operation the possibility of removal of the larynx with the growth must be kept in mind; this being so, it is probably best to perform tracheotomy before doing a lateral pharyngotomy; when the growth is reached the whole larynx may be turned round so as to expose fully the back of the cricoid with the ulcer. It is most important in removing an extensive ulcer to leave a strip of mucous membrane of the pharynx, so as to allow of the subsequent growth of this strip to form a new pharynx. Apart from radical operative treatment there is radium, which has been used with considerable success.

In the cases where the growth extends upwards and forms large masses behind the tongue, both radium and diathermy may be used; I have seen much benefit in one such from radium emanations. A woman had a large mass of growth almost entirely blocking the pharynx leading to considerable dyspnœa preventing rest at night, and dysphagia; she also had much pain. Into this mass I inserted a small tube of radium emanations and left it there for twenty hours, at the end of which time it was coughed out; at once the patient got relief, she lost her pain, she slept quietly and she swallowed better, and this effect lasted some little time, about two to three months.

A second patient, a woman of forty-five, had a similar mass in the pharynx so big as to be visible on depressing the tongue; she also had a mass of breaking-down glands in the neck. In this case Dr. Iredell used diathermy, and though the result was not by any means so good as that obtained from the radium, yet certainly the mass diminished in size and the patient was more comfortable.

The prognosis is very bad, not more than seven to ten months on the average in untreated cases; in one of the cases quoted above the patient lived nearly two years after the onset of symptoms and died of exhaustion. Undoubtedly, early operation holds out the best hope, and for early operation early diagnosis is essential, and this is only to be obtained by examination with direct vision through Brüning's tubes.

Some Further Notes about the Feeding of Babies with Undiluted Citrate Milk.

By Dr. H. C. MANN.

Three years ago I wrote an article in the Gazette giving an account of the success which had been obtained with this method of baby-feeding at the Evelina Hospital. I have recently been asked to bring my notes up to date, and to give fuller details of the quantities of milk prescribed at different ages, of the caloric food value per diem which is required, and of indications for change in the quantity or quality of the diet.

I first started whole-milk feeding with the idea of treating rickets and preventing its onset. Rickets is the greatest of all our South London tragedies, because it is an evil which might always have been avoided, instead of being one of the commonest troubles for which children are brought to hospital. After a trial of whole-milk feeding extending now over eight years at the Evelina, I can say with absolute confidence that if this method of hand-feeding were adopted when breast-milk has failed or proved unsuitable, rickets as a disease with so many complications dangerous to infant life would disappear. During the above-mentioned period literally hundreds of children have been fed successfully in this way; in a great many cases their subsequent growth and development has been followed past the age for beginning school, and into the years of the second dentition. I can honestly say that I have given a great deal of time to the writing of regular and accurate notes of these cases with full details of the child's condition, of incidental complications, and of change in the method of feeding. These notes are filed, and can be seen at any time by anyone who is interested in the subject. The babies themselves come in many cases from a considerable distance - from Dartford on the east, Farnborough and Purley on the south, Kingston on the west. They do not seem to suffer in any way from these long journeys, and a line drawn through the above-named places defines the area in which they live. I mention this fact to explain that many of the mothers are more fortunately situated than those in Southwark and Bermondsey homes, and this leaven of a better class of parent is of great advantage to the physician at

"Out-Patients," for the poorer type of mother is stimulated thereby to take a greater care of her child; she sees around her efforts made to keep children clean, she notices the best type of valved feeding bottle in use, and she begins to keep her own weight chart and her own register of total feeds per diem.

In the great majority of cases when a wasting baby is brought to hospital, the original cause of the trouble is to be found in the fact that the food chosen has not suited the child, either as regards its composition, or its caloric value. Constitutional disease and infective enteritis, except in prolonged hot weather, are far less commonly responsible for wasting than errors of dietary.

An examination of Out-Patient notes shows that most often the sequence of events is as follows:—

1. The breast milk fails, the baby is fed for a few weeks on diluted cow milk, and owing to the low caloric value of the diet the child fails to gain, or perhaps loses in weight.

2. A change is then made, either to a condensed milk which contains a high percentage of carbohydrate, or to a dried milk which may yield a correct percentage mixture, but which contains its fat in the form of an emulsion that *does not prove easy of digestion*. In the former case the mixture is deficient in fat, and in addition the child is very likely to develop an intolerance for sugar; in the latter case various forms of fat dyspepsia may arise and give rise to further disturbance of nutrition. In either case rickets and scurvy are dangers in the immediate future.

I propose to consider, later, other causes for failing nutrition, but it is well to remember first of all that when working in a poor district such as Southwark, most of our trouble with baby-feeding arises in the above-mentioned way, and that in 95 per cent. of the cases the employment of whole citrated milk is immediately successful.

First of all a word may be said as to the directions which are given to the mother or nurse. She is told to scald the milk as soon as she obtains it by standing the jug inside a saucepan of water, the water is then raised to the boil, and maintained at the boil for ten minutes; the jug of milk is then rapidly cooled by standing in cold water; it is kept all day standing in cold water, covered from dust, and in the coolest place in the house. I have never seen any of the ill-effects attributed to boiled milk arise from the use of fresh milk which has been treated in the above way. It is interesting to record the fact that although I am frequently testing milk samples for fat by means of the cream-gauge at Out-Patient's, I have only on two occasions in the course of eight years found the fat percentage to work out lower than 3 per cent., and usually it is 3·5 per cent., or even higher. Government supervision in London is strict, and the fines which are imposed for adulteration are very heavy. On the other hand, a week never passes without someone complaining at Out-Patient's that the dairyman's measure is short, and that five four-ounce feeds cannot be obtained from the pint which has been delivered.

These are the quantities of milk with which I work at Out-Patients; the figures which are given may be taken as a *good working guide for the great majority of cases*. In some instances, if the child is ill or some form of dyspepsia is already present, slightly smaller quantities may be indicated for a week or two, but a return will very soon be made to standard totals:—

a. Baby, 7 days old, weight 8 lbs.
Feeds 9 per diem, 2 oz. each.
Total whole milk, 18 oz. = 360 calories.
(1 oz. milk, 3·5 per cent. fat = 20 calories),
or 45 calories per pound.

b. Baby, 14 days old, weight 8 lbs. to 8½ lbs.
Feeds as above,
or 45 calories per pound.

c. Baby, 1 month old, weight 9 lbs.
Feeds 9 per diem, 2½ oz. each.
Total whole milk, 22½ oz. = 450 calories,
or 50 calories per pound.

d. Baby, 2 months old, weight 10 lbs.
Feeds 8 per diem, 3 oz. each.
Total whole milk, 24 oz. = 480 calories.
In addition—
Malt extract one teaspoonful dissolved in half an ounce of warm milk (not given with milk feeds) = 30 calories, containing 90 grains maltose.
Total, 510 calories,
or 51 calories per pound.

e, Baby, 3 months old, weight 11 lbs.
Feeds 8 per diem, 3½ oz. each.
Total milk, 28 oz. = 560 calories.
Malt extract as above = 30 calories.
Total, 590 calories,
or 53 calories per pound.

f. Baby, 4 months old, weight 12 lbs.
Feeds 7 per diem, 4 oz. each.
Total milk, 28 oz. = 560 calories.
Malt extract, one and a half teaspoonfuls in half an ounce of warm milk (containing 135 grains maltose) = 40 calories.
Total, 600 calories,
or 50 calories per pound.

g. Baby, 6 months old, weight 14½ lbs.
Feeds 7 per diem, 5 oz. each.
Total milk, 35 oz. = 700 calories.
Malt extract as above, 40 calories.
Total 740 calories,
or 50 calories per pound.

h. Baby, 8 months old, weight 17 lbs.
Feeds 6 per diem, 6 oz. each.
Total milk, 36 oz. = 720 calories.
Malt extract, two teaspoonfuls in three quarters of an ounce of warm milk = 55 calories (containing 180 grains maltose).
Total, 775 calories,
or 45 calories per pound.

i. Baby, 10 months old, weight 19 lbs.
Feeds 5 per diem, 7 oz. each.
Total milk, 35 oz. = 700 calories.
Malt extract, three teaspoonfuls in one ounce of warm milk = 80 calories (containing 270 grains maltose).
Total, 780 calories,
or 41 calories per pound.

In every case these whole milk feeds are citrated. A very limited number of cases will be found where the undiluted milk can be taken without citration, but when you are dealing with hundreds of cases, the number that can be so fed will be found to be small, and it is a wiser plan to always citrate the feed, seeing that no harm results from the practice, and there is no means of telling without trial which are the babies of Spartan constitution for whom such non-citrated milk has no terrors. Dr. Cautley,[1] writing of non-citrated whole milk, says that it is "a frequent cause of indigestion and constipation in infancy." That has been my experience also, unless the milk has been citrated.

Another point of importance is that the milk feeds are never sweetened. The baby is, from the first, accustomed to the slightly salty taste of the citrated milk, extra carbohydrate with the feed is not allowed, and it will not be found that saccharine is required.

Extra carbohydrate in the form of malt extract is given as a general rule from the age of two months onwards. In some cases it may be tolerated when the baby is younger and smaller; in others, there is intolerance for maltose or carbohydrate additions in any form throughout the whole of the first year, though it may be said at once that this is quite uncommon. The malt is never added to the regular milk feeds, but the total quantity ordered per diem is dissolved in a little warm milk, and given by spoon in two or three portions between the bottle feeding times. The reason for this arrangement is quite obvious. In the event of any gastro-intestinal disturbance, accompanied by vomiting or diarrhœa, the extra-carbohydrate can at once be eliminated from the dietary without altering the taste or composition of the main milk feeds, which remain relatively low in carbohydrate percentage, and high in proteid. Everybody knows how much trouble is experienced when a baby is ill, quite apart from the illness itself, in connection with a change in dietary, and a change is very often imperative if feeding has been carried on with a cream and carbohydrate mixture, or with a patent food. The child very often refuses nourishment simply on account of a change in taste, and much ground is lost before regular feeding can be established. Experience has shown that at such danger times in the first year of life whole-milk feeding is invaluable, providing a small bulk of feed with a high caloric value, and, by means of citration, allowing a relatively high percentage of proteid without signs of indigestion.

Sometimes in hot weather, when the child is thirsty, boiled filtered water may be given between the feeds, but only small quantities are necessary, and it is seldom required. Difficulty in keeping to intervals between feeding times, or the passage of concentrated urine, may be signs that a little more water is necessary.

It is very interesting to compare the food values which have been given above with those which are possible when diluted milk is employed, and for this purpose I have put down in detail the scheme of feeding which is recommended by Clifford Grulee[2] of Chicago, whose teaching and practice is largely that of the Finkelstein school.

1. Baby, 7 days old, weight 8 lbs.
Milk, 9 oz. (4 per cent. fat 1 oz. milk = 21 calories).
Water, 9 oz.
Feeds, 6 per diem, 3 oz. each. 189 calories
or 23·5 calories per pound.

2. Baby, 14 days old, weight 8 lbs.
   Milk, 9 oz. = 189 calories.
   Water, 9 oz.
   Malt food, ¼ oz. = 30 calories.
   Feeds, 6 per diem, 3 oz. each.
   Total, 219 calories.
   or 27·3 calories per pound.

3. Baby, 2 months old, weight 10 lbs.
   Milk, 12 oz. = 252 calories.
   Water, 10½ oz.
   Malt food, ¾ to 1 oz. = 90 to 120 calories.
   Feeds, 5 per diem, 4½ oz. each.
   Total, 372 calories,
   or 37·2 calories per pound.

4. Baby, 3 months old, weight 11 lbs.
   Milk, 16½ oz. = 346 calories.
   Water, 8½ oz.
   Malt food, 1 oz. = 120 calories.
   Feeds, 5 per diem, 5 oz. each.
   Total, 466 calories,
   or 42·3 calories per pound.

5. Baby, 6 months old, weight, 14 lbs.
   Milk, 21 oz. = 441 calories.
   Water, 14 oz.
   Malt food, 1 oz. = 120 calories.
   Feeds, 5 per diem, 7 oz. each.
   Total, 561 calories,
   or 40 calories per pound.

A glance at these two methods of baby-feeding shows that by the citrated whole-milk method, the feeds are in every case smaller in bulk and yet have a greater caloric value. This is undoubtedly a tremendous advantage when dealing with wasted and premature babies, and provided that the claim of freedom from dyspepsia can be substantiated, such a method is bound to succeed where others fail. It should be mentioned, in passing, that Grulee employs a diluted milk as a standard feed, because in common with many who have visited the Finkelstein clinic he believes fat-dyspepsia and intolerance to be a common cause of trouble with the artificially-fed baby. To this point I shall return later. Grulee also employs a four-hourly interval between the feeds, even for a baby of seven days old and of eight pounds weight, because he believes "that cow's milk mixtures do not leave the stomach for at least three hours after ingestion." These long-range feeding times demand feeds rather larger than those commonly employed, and Grulee[3] systematically employs a feed larger than the child's stomach capacity, relying upon the fact that "a large amount of the *fluid* contents of the milk passes the pylorus in a very few minutes." I have, however, known many a baby of seven days old and eight pounds weight who would return a three ounce feed, invariably, even when four hourly intervals were practised, and when working with children who are *under* the weight of five pounds, large feeds and long intervals become an impossibility, no matter how patient and painstaking be the nurse. It is also worthy of note that I have found the stomach of a baby four months old to be empty at an autopsy when death had taken place one and a half hours after a 105 c.c. feed of citrated milk. For this reason I question whether, on the score of residual milk, one is justified in employing such lengthy waits between the bottles.

A word may be useful as to the amount of citrate salt required. I work at Out-Patients with a solution, and a teaspoonful of this containing the necessary amount of sodium citrate in a drachm of distilled water is added to each feed. Two grains of sodium citrate are used for each ounce of milk until the feed is a four ounce one, when eight grains are employed. For feeds larger than four ounces—that quantity of citrate is often sufficient, if more citrate is required on account of indigestion, I use equal quantities of sodium and potassium citrate so as to prevent the possibility of sodium-retention. Thus, for five or six ounce feeds, five grains of each salt in a teaspoonful of distilled water will be added to each bottle. Those quantities never need be exceeded. Sometimes if diuresis is free, the amount of potassium salt may be reduced, but that matter is easily adjusted. There are a certain number of children who manage whole milk quite well with the addition of only one grain or one and a half grains of sodium citrate to each ounce of milk, but experience has shown that it is wiser in the great majority of cases to employ the larger quantity, that is, two grains to the ounce, when the feed is small and the child is feeble, reducing the percentage of citrate as the feeds become larger than four ounces.

The age at which it is possible to use whole milk without citration varies very much. Sometimes at the age of ten months no citrate is required, and at other times it is eighteen months. Even when the child is much older the mother occasionally returns to obtain the prescription because she finds that milk is tolerated so much better, and is taken more readily when it is modified in the above mentioned way. Similar intolerance for milk, when not citrated, is also observed at times in adult life.

Premature babies.—Feeding troubles occur very frequently indeed among premature babies. The mother's own illness has so often been the cause of prematurity that breast-feeding is either not possible or is given up very soon after birth. At other times the weakly condition of the child makes either breast-feeding or bottle-feeding a matter of very great difficulty. Two factors especially are responsible for trouble—the child's stomach is very small, and the tolerance for food, that is to say the power of digestion and assimilation, is very low. Grulee, after an extensive experience of American and Continental clinics, and with a preference for the practice of Finkelstein, actually says that "any attempt to feed these infants artificially is practically certain to meet with failure," and that "any successes with food other than breast-milk may be regarded as the result of good luck rather than of good judgment."[4] At the Evelina, I make a practice of feeding such premature children by the whole milk method as soon as breast-milk is found to be failing, and whether these feeds are given to supplement breast-feeds, or as the only form of nourishment, they will be found to provide the most reliable way of successfully rearing the baby

Many of these cases are examples of congenital syphilis. It is customary to teach that such children should always be fed, for preference, at the breast, at least those directions appear in every British or American text-book with which I am acquainted, but as I see the disease in South London, successful breast-feeding for syphilitic babies is only obtained in a minority of cases, and for choice I should feed the child by hand with whole milk. That statement is made after a great deal of trial with various methods of feeding, and with the advantage of observations made in the later years of childhood.

The extreme importance of maintaining a normal body-temperature is generally recognised. Budin has drawn attention to the high mortality among premature infants whose temperature is allowed to remain consistently subnormal. The rapidity with which body-heat is lost is explained by the relatively large surface area as compared with the mass, while the child remains small. The body should always be oiled and wrapped in cotton wool.

The undermentioned figures, dealing with the size of feeds and the total quantity of milk required, may be found useful as a guide. As a general rule it may be said that when the baby is premature and between the weight of three and six pounds you should start feeding at 50 calories to the pound, and work up to about 60 per pound, which will in nearly every case be tolerated. Certainly in some cases the latter figure will be exceeded. Thus I have notes of a child of four pounds weight who always took ten feeds of one and a half ounces (total, 300 calories or 75 calories per pound), and of another, five pounds weight, who always required a two ounce feed and invariably took ten of them (total, 400 calories or 80 per pound). Both these children are now between four and five years old, and they have never at any time given anyone anxiety as regards their general health. Such exceptional cases will not infrequently be seen in any large clinic.

Average quantities required:—

Weight of baby.	Feeds.	Total Milk.	Total calories.	Calories per lb.
3 lbs.	Ten—¾ oz.	7½ ozs.	150	50
	Ten—1 "	10 "	200	66
4 "	Ten—1 "	10 "	200	50
	Ten—1¼ "	12½ "	250	62
5 "	Ten—1¼ "	12½ "	250	50
	Ten 1½ "	15 "	300	60
6 "	Ten—1½ "	15 "	300	50
	Nine—2 "	18 "	360	60

The following notes, taken at Out-Patients, of premature babies who were fed in the above way are interesting examples among a very large number of successful cases. The fact that the gain in weight is not always a steady increase is easily explained by the presence of accidental troubles common to babyhood, such as bronchitis, summer diarrhœa, measles, whooping-cough, and the general nervous upsets which accompany "teething." Allowing for these complications, the figures give a very good idea of the results which may be obtained and of the monthly gain in weight. Children under the weight of 8 lbs. attend twice a week, under 13 lbs. once a week, and when over that weight once a fortnight. Most of the mothers keep their own weight charts and bring to hospital, when they come, their own register of total feeds per diem. The keen interest which is taken by them and the interest which they show, even in the very poorest homes, is very encouraging and perhaps surprising to those who believe that there is no patience or perseverence among the poor. The simplicity of the method is partly responsible for its success.

Examples of Premature Babies.

1. E. B., a baby girl, delivery at 8 months. Breast milk feeding for only 3 weeks, then bottle feeding with equal parts of cow's milk and water (sweetened) for

2 months. Two different forms of patent food were then tried, with milk, for the next 2 months; no progress was made. The child was brought to hospital at the age of 5 months. The following weighings were recorded: at 5 months, 4 lb. 2 oz.; at 6 months, 5 lb. 12 oz.; at 7 months, 8 lb.; at 8 months, 9 lb. 12 oz.; at 9 months, 11 lb. 8 oz.; at 12 months, 15 lb.; at 15 months, 19 lb. 8 oz.; at 2 years, 25 lb. 4 oz.

2. H. D., a baby boy, delivery at 8 months. Breast milk feeding was only possible for a week. The child was then fed on 2 oz. feeds of a cow's milk-cream-lactose mixture for five weeks. Little progress was made. He was brought to hospital at the age of 6 weeks. The following weighings were made: at 6 weeks, 4lb. 4oz.; at 10 weeks, 5lb. 8oz.; at 3 months, 6 lb. 3 oz.; at 4 months, 7 lb. 3 oz.; at 5 months, 8 lb. 15 oz.; at 6 months, 10 lb. 15 oz.; at 7 months, 13 lb. 6 oz.; at 9 months, 16 lb. 2 oz.; at 10 months, 17 lb. 7 oz.; at 14 months, 21 lb. 2 oz.; at 2 years, 30 lb.

3. F. H., a baby girl, delivery at 7½ months; weight at birth, 4 lb. The child was fed at the breast for 3 weeks, and, failing to gain weight, was weaned. During the next week a diluted milk mixture was tried and also a sweetened condensed milk; vomiting was troublesome. She was brought to hospital at the age of one month. The following weighings were made: at 4 weeks, 3 lb. 4 oz.; at 7 weeks, 3 lb. 15oz.; at 2 months, 5 lb. 4 oz.; at 3 months, 6 lb. 4 oz.; at 4 months, 7 lb. 3 oz.; at 5 months, 9 lb. 1 oz.; at 6 months, 10 lb. 12 oz.; at 7 months, 12 lb. 5 oz.; at 8 months, 14 lb. 8 oz.; at 9 months, 15 lb.; at 10 months, 15 lb. 12 oz.; at 12 months, 16 lb. 8 oz.; at 13 months, 17 lb. 4 oz.; at 17 months, 20 lb. 4 oz.; at 18 months, 22 lb. 2 oz.; at 20 months, 23 lb. 10 oz.

4. T. G. and H. G., twins, delivery at 7½ months. No breast feeding was possible. For the first three weeks a milk-water-lactose mixture was given, and then a patent food was substituted for the lactose, the latter mixture being continued for three weeks. Practically no progress was made. The children were sent to hospital at the age of 6 weeks. The following weighings were taken:—

	Thomas.	Henry.
At 6 weeks	4 lb. 7 oz.	4 lb. 0 oz.
At 9 weeks	5 lb. 5 oz.	4 lb. 11 oz.
At 3 months	6 lb. 8 oz.	6 lb. 0 oz.
At 4 months	8 lb. 0 oz.	7 lb. 12 oz.
At 5 months	9 lb. 0 oz.	9 lb. 0 oz.
At 6 months	8 lb. 15 oz.	9 lb. 7 oz.
At 7 months	10 lb. 5 oz.	10 lb. 8 oz.
At 8 months	11 lb. 2 oz.	10 lb. 6 oz.
At 9 months	11 lb. 8 oz.	11 lb. 14 oz.
At 11 months	12 lb. 7 oz.	12 lb. 10 oz.
At 12 months	13 lb. 6 oz.	13 lb. 5 oz.
At 13 months	14 lb. 0 oz.	14 lb. 0 oz.
At 18 months	18 lb. 9 oz.	18 lb. 0 oz.
At 22 months	20 lb. 8 oz.	20 lb. 0 oz.

5. H. K., a baby boy, delivery at 8 months. Breast feeding was given for four and a half weeks, and was then discontinued on account of vomiting which occurred after every feed. Bottle feeding was then substituted, using a milk and barley water mixture (equal parts); vomiting continued. At the age of 6 weeks the child was brought to hospital. Progressive wasting was reported. Pyloric spasm was diagnosed. Citrated and alkaline feeds of whole milk were employed, using sodium citrate 2 gr., sodium bicarbon. ½ gr. to each ounce of milk. The sodium bicarbonate was continued until the age of 6½ months, when citration was alone employed. The following weighings were recorded: at 6 weeks, 3lb. 15oz.; at 7 weeks, 4lb. 5oz.; at 8 weeks, 4 lb. 10 oz.; at 3 months, 4 lb. 13 oz.; at 4 months, 5 lb.; at 5 months, 5 lb. 6½ oz.; at 6 months, 7 lb. 11 oz.; at 7 months, 10 lb. 6 oz.; at 9 months, 14 lb. 8 oz.; at 10 months, 16 lb. 4 oz.; at 12 months, 19 lb.; at 14 months, 22 lb. 14 oz.; at 16 months, 23 lb. 8 oz.; at 17 months, 24 lb.

6. F. L., a baby boy, delivery at 7½ months. Breast feeding was only possible for a fortnight, then a milk-barley-water (sweetened) mixture was given for a week; no progress was made. The child was brought to hospital at the age of three weeks. The following weighings were recorded: at 3 weeks, 4 lb. 10 oz.; at 2 months, 5 lb. 10 oz.; at 3 months, 6 lb. 3 oz.; at 4 months, 7 lb. 1 oz.; at 5 months, 8 lb. 4 oz.; at 6 months, 10 lb. 7 oz.; at 7 months, 12 lb. 8 oz.; at 8 months, 14 lb. 7 oz.; at 9 months, 16 lb. 6 oz.; at 10 months, 18 lb.; at 11 months, 19 lb.; at 15 months, 22 lb.

7. M. R. and M. R., twins, baby girls, delivery at 7 months. Although breast milk was plentiful, the babies were very weak and unable to take it. For 8 weeks a milk-water-albulactin-lactose mixture was given, but no progress was made. At the age of 9 weeks the children were sent to hospital. The following weighings were taken:—

	Muriel.	Marjory.
At 9 weeks	5 lb. 12 oz.	4 lb. 10 oz.
At 11 weeks	6 lb. 4 oz.	5 lb. 2 oz.
At 3 months	6 lb. 10 oz.	5 lb. 12 oz.
At 4 months	7 lb. 10 oz.	6 lb. 8 oz.
At 6 months	10 lb. 6 oz.	8 lb. 10 oz.
At 7 months	12 lb. 0 oz.	10 lb. 0 oz.
At 8 months	13 lb. 12 oz.	11 lb. 8 oz.
At 9 months	14 lb. 13 oz.	12 lb. 2 oz.
At 10 months	15 lb. 12 oz.	13 lb. 4 oz.
At 11 months	16 lb. 3 oz.	13 lb. 15 oz.
At 12 months	17 lb. 2 oz.	14 lb. 14 oz.
At 15 months	20 lb. 0 oz.	16 lb. 14 oz.
At 16 months	22 lb. 0 oz.	18 lb. 15 oz.
At 22 months	26 lb. 2 oz.	22 lb. 0 oz.
At 24 months	26 lb. 8 oz.	23 lb. 0 oz.
At 27 months	30 lb. 4 oz.	23 lb. 12 oz.

8. A. T., a baby-boy, delivery at 8 months. The child was given breast milk alone for seven weeks.

but, failing to gain weight, was brought to hospital. The following weighings were recorded: at 7 weeks, 5 lb. 8 oz.; at 9 weeks, 6 lb. 6 oz.; at 11 weeks, 7 lb. 6 oz.; at 3 months, 8 lb. 2 oz.; at 4 months, 9 lb. 4 oz.; at 5 months, 11 lb. 2 oz.; at 6 months, 11 lb. 8 oz.; at 7 months, 12 lb. 6 oz.; at 8 months, 13 lb. 6 oz.; at 9 months, 14 lb. 8 oz.

9. L. M., a baby girl, delivery at 8 months in the York Road Lying-in Hospital. Weight at birth 5 lb. 8 oz. When the mother and baby were discharged from hospital the baby had regained her birth weight. There was no breast milk. The baby was fed upon a milk-water (3 : 1) mixture with lactose. At 5 weeks the weight was only 5 lb. 2 oz., and the baby was brought to hospital. The following weighings were recorded: at 5 weeks, 5 lb. 2 oz.; at 6 weeks, 5 lb. 8 oz.; at 2 months, 6 lb.; at 3 months, 8 lb. 8 oz.; at 4 months, 10 lb. 3 oz.; at 5 months, 11 lb.; at 6 months, 12 lb. 1 oz.; at 6½ months, 12 lb. 6 oz. The child has whooping-cough at the present time, but there is no trouble with the feeds.

10. J. F., a baby boy, delivery at 8 months. The child was fed with breast milk alone for the first three weeks. No progress was made, the weight falling steadily. Supplemental bottle feeds of Nestle's sweetened milk were then given for a week without success. At four weeks a cow's milk-water (equal parts) mixture with lactose was given for six weeks; no progress. At the age of ten weeks the baby was brought to hospital. The following weighings were recorded: at 10 weeks, 6 lb. 10 oz.; at 12 weeks, 7 lb. 6 oz.; at 3 months, 8 lb.; at 4 months, 9 lb. 8 oz.; at 5 months, 11 lb. 12 oz.; at 6 months, 13 lb. 5 oz.; at 8 months, 16 lb. 8 oz.; at 9 months, 17 lb. 8 oz.; at 11 months, 19 lb.; at 12 months, 19 lb. 7 oz.

Intolerance for milk-fat.—The success of such a method of baby-feeding, especially with under-sized premature children, makes it impossible to accept the view which I mentioned above, that fat dyspepsia and intolerance is a common cause of trouble when cow's milk is employed. Even when premature babies alone are considered, it is the rarest possible event for a diluted milk to be required, and when such a diluted feed is found to be imperative, either on account of general ill-health, or in the advent of infective disease, it is only necessary for a few weeks, and a return can soon be made to a whole-milk dietary. In a previous number of the Gazette I have drawn attention to the fact that even during an attack of "summer diarrhœa" a considerable degree of fat-digestion is possible, and if these gross disorders of the gastro-intestinal tract are excluded, examples of fat-dyspepsia are very uncommon. Most of the cases that occur are due to a careless use of cream and top-milk mixtures, and to the adoption of a percentage system of feeding. By the correct addition of whey, cream, or lactose to top or bottom milk, a mixture may be obtained which agrees in percentage composition with human milk, but it does not follow that the baby will be able to digest the fat so well as is usually the case with fresh cow's milk when the fat is in its natural state of emulsion, and has not been separated from the milk by mechanical means. For this reason it is possible to explain the more frequent occurrences of Milchnährschaden and Zuckernährschaden in clinics where percentage feeding is largely employed.

Intolerance for carbohydrates, either starches or sugar, is not nearly so common among babies as is supposed. Carbohydrates are nearly always given to excess in the form of sweetened condensed milk, or as patent foods, but not infrequently far too large a quantity of cane-sugar is added to a diluted milk mixture. In each case the fat percentage of the resulting mixture is about 1 per cent., very often it stands at a lower figure, and much of the trouble which arises when either of these three methods of feeding is adopted, is due to the deficiency of fat in the dietary. Rickets, as I see it among South London children, is almost always produced in this way with condensed or diluted cow's milk, and the immediate improvement which follows the administration of undiluted fresh cow's milk is one of the strongest arguments for the universal adoption of such a method of baby-feeding in a poor district like Southwark. Provided that the baby is fed upon whole-milk when hand feeding becomes necessary—rickets will never arise.

It is interesting to notice that nearly always when a rachitic baby is put on to a whole milk dietary, the weight immediately falls, although feeds may be taken quite well, the loss usually measuring between 4 and 10 ounces, and after an interval of a week or two the steady rise in weight begins, while the flabby fat gives place to the firm subcutaneous and muscular tissue of the healthy baby.

Several of the members of the International Medical Congress who came to see these out-patient children last year, expressed the opinion that the results obtained were convincing proof of the general excellence of the London milk supply and the efficiency of government inspection. Among a large number of milk samples which I have tested for fat during the past eight years, on only two occasions has the analysis showed a lower percentage than that required by law.

The following figures are typical of the results which may be obtained from feeding a rachitic baby with fresh cow's milk, citrated undiluted, and malt, following the general scheme which I have detailed above:—

C. R., a baby girl, delivery at 8 months. The child was fed at the breast for nine weeks, and from that age, as the breast milk was failing, she was fed on sweetened diluted milk. When 11½ months old she was brought to hospital with well-marked signs of rickets. Whole citrated unsweetened milk was ordered, and two drachms, by weight, of malt extract were allowed daily. The following weighings were recorded: at 11½ months, 13 lb. 8 oz.; at 12 months, 14 lb.; at 13 months, 15 lb. 8 oz.; at 13½ months, 16 lb. 4 oz.; at 14 months, 16 lb.; at 15 months, 16 lb. 14 oz.; at 16 months, 18 lb. 2 oz.; at 17 months, 19 lb. 5 oz.; at 18 months, 20 lb. 12 oz.; at 19 months, 22 lb. 5 oz.; at 20 months, 23 lb. 2 oz.; at 22 months, 24 lb. 8 oz. Note. —At the age of 13½ months the child had an attack of "summer diarrhœa," which was then prevalent. The amount of milk given per diem was reduced by one-third of its total bulk, all malt was omitted, the feeds were both citrated and made alkaline by the addition of sodium bicarbonate. A creosote and morphia mixture was prescribed to keep the diarrhœa in check. After five weeks malt was again allowed, the total milk having been increased previously. At the age of 16 months the amount of malt was increased to a daily total of six drachms by weight. At the age of 17 months rusk and milk was given twice daily. Twelve teeth had erupted at 18 months. At the age of 20 months egg and bread and butter had been added to the dietary, the milk total remaining at about two pints per diem. By the age of 22 months there had been further additions in the form of gravy and bread, potato, green vegetable, and custard, the milk minimum total standing at 30 ounces. Sixteen teeth had erupted.

I have always found that at an early age or when the baby is small and weakly maltose is tolerated far better than any other form of carbohydrate, and when given in the form of malt extract that preparation has a very useful laxative action. Nearly all so-called constipation in babies is due to the inability of the child to empty the rectum when the stool is hard and rather dry, and for this reason it is the greatest possible mistake to use purges such as grey powder or castor oil. Regular administration of these drugs only leads to habitual sluggishness of the bowels, and in later years to general intestinal stasis. The trouble is overcome by the use of liquid paraffin, which is best given in the form of an emulsion containing also a volatile oil. A teaspoonful of such an emulsion, containing 50 per cent. of liquid paraffin, may be required two or three times daily until the child is stronger and begins to run about. It is very rarely that more drastic measures are required.

It can easily be understood that if such figures can be obtained when working in an out-patient department where the majority of children are living in a very poor district, children whose parents often and often deny themselves food in order that a milk bill of two shillings and fourpence per week may be paid, still more favourable results can be claimed when surroundings are all of the best and livelihood is never precarious. The following six records referring to cases in private practice, all of which have been fed in the same way, do not require any further explanation.

In each instance breast-feeding was impossible and hand-feeding with whole citrate milk was started soon after birth.

No. 1. At four months, 12 lbs. 4 oz.; at five months, 14 lbs. 8 oz.; at seven months, 17 lbs. 4 oz.; at nine months, 20 lbs. 12 oz.

No. 2. At twelve weeks, 13 lbs. 6 oz.; at four months, 16 lbs.; at six months, 20 lbs.

No. 3. At three months, 13 lbs.; at seventeen weeks, 15 lbs. 8 oz.; at six months, 18 lbs.; at twelve months, 27 lbs.

No. 4. At four months, 17 lbs. 4 oz.; at six months, 21 lbs.; at nine months, 23 lbs.

No. 5. At three months, 15 lbs. 4 oz.; at five months, 18 lbs.; at seven months, 21 lbs. 12 oz.; at eleven months, 27 lbs.

No. 6. At four weeks, 10 lbs. 6 oz.; at thirteen weeks, 14 lbs. 2 oz.; at six months, 19 lbs. 4 oz.; at eight months, 21 lbs. 2 oz.; at twelve months, 26 lbs. 4 oz.

REFERENCES.

1. E. Cautley. Diseases of Children. (Garrod, Batten and Thursfield, 1913.)
2. Clifford Grulee. Infant Feeding, 1912. "Artificial Feeding for the Normal Infant," Chapter xi.
3. Clifford Grulee. Infant Feeding. Chapter xi.
4. Clifford Grulee. Infant Feeding. Chapter xviii. "The Premature Infant."

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Guy's Hospital.

Tables showing the Cost of Maintenance of the Electrical and Actinotherapeutic Department, the Massage Department, the Medical Radiographic, the Surgical Radiographic, and the Photographic Departments for 1913.

ELECTRICAL AND ACTINOTHERAPEUTIC DEPARTMENT.

Year.	Number of Patients and Treatments.	Apparatus and Tubes.	Repairs and General Sundries.	Salaries.	Current.	Total.	Receipts from Patients, etc.
		£	£	£	£	£	£
1909	1,045 35,000	152	69	451	49	721	98
1910	1,206 43,731	134	119	450	38	741	131
1911	1,405 49,782	100	68	445	25	638	98
		Ap. Tbs.					
1912	1,539 48,871	£54 £38	57	451	24	624	83
1913	1,401 40,130	£5 £40	93	446	28	612	29

Under Salaries are included payments made to the Physician and Surgeon in Charge of the Departments, the Electrician, the Sister in Charge of the Light Department, the Staff Nurse, Eight Probationers, and a Wardmaid. The Board and Uniform of the Nursing and Domestic Staff are not included.

MASSAGE DEPARTMENT.

Year.	No. of Cases.	Cleaning.	Salaries.	Total.
		£	£	£
1909	566	4	22	26
1910	827	4	31	35
1911	959	4	31	35
1912	595	4	37	41
	Treatments.			
1913	580 5,389	4	49	53

There are Three Masseuses, a Staff Nurse, and Two Probationers receiving salaries, and at the beginning of 1914 there were 28 Sisters and Nurses taking Massage cases. At the present time there are about 95 cases receiving treatment.

MEDICAL RADIOGRAPHIC DEPARTMENT.

Year.	Apparatus.	Repairs and General Sundries.	Photographic Materials.	Development of Plates.	Cleaning.	Honor. of Radiographer.	Current.	Total.
	£	£	£	£	£	£	s. d.	£
1909	12	5	34	43	1	100	15 4	196
1910	15	8	39	54	1	100	6 10	217
1911	18	18	64	—	£1 10s.	100	11 6	202
1912	44	32	80	—	£3 5s.	100	5 0	260
1913	8	26	76	—	£3 5s.	—	11 0	124

SURGICAL RADIOGRAPHIC DEPARTMENT.

Year.	Apparatus and Tubes.	Repairs and General Sundries.	Photographic Materials.	Cleaning.	Honor. of Radiographers.	Current.	Total.
	£	£	£	£	£	£ s. d.	£
1909	45	14	158	1	250	0 13 6	469
910	344	38	175	1	250	0 17 6	809
911	127	33	255	2	250	1 1 6	668
	Ap. Tbs.						
1912	£358 £99	35	197	£3 5s.	254	0 12 6	947
1913	£13 £163	46	154	£3 5s.	228	0 11 7	608

PHOTOGRAPHIC DEPARTMENT.

Year.	Number of Patients Photographed.	Plates, etc.	Chemicals.	Cleaning.	Salary of Photographers.	Total.
		£	£	£	£	£
1909	234	6	11	1	117	135
1910	265	11	17	1	117	146
1911	331	14	43	3	145	205
1912	211	17	63	—	180	260
1913	218	36	52	—	189	277

MEDICAL RADIOGRAPHIC DEPARTMENT
(and Work done for Physicians in Surgical Radiographic Department).

	In-Patients.		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
	Screened.	Skiagraphed.	Screened.	Skiagraphed.			
	768	485	356	147	£48 5 0	£9 18 8	£58 3 8

SURGICAL RADIOGRAPHIC DEPARTMENT.

					£ s. d.	£ s. d.	£ s. d.
Sir Arbuthnot Lane ...	47	314	—	3	18 11 11	0 4 5	18 16 4
Mr. Dunn	71	247	—	—	13 7 5	0 12 1	13 19 6
Sir Alfred Fripp ...	22	214	—	1	12 19 10	0 6 8	13 6 6
Mr. Steward	38	222	4	—	13 0 8	0 10 6	13 11 2
Mr. Fagge	27	53	9	7	4 8 3	0 8 11	4 17 2
Mr. Rowlands... ...	13	50	11	6	3 8 6	0 3 10	3 12 4
Mr. Turner	6	33	5	7	1 17 8	0 2 6	2 0 2
Mr. Hughes	21	53	2	5	3 6 4	0 10 8	3 17 0
Mr. Davies-Colley ...	3	28	14	11	2 2 5	0 0 7	2 3 0
Specialists	10	51	1	10	5 6 11	3 4 0	8 10 11
Surgery	—	—	3,144	1,175	54 4 1	1 15 7	55 19 8
Dental Department ...	—	1	7	178	4 11 11	0 4 2	4 16 1
Bright Ward	2	21	1	—	1 13 9	0 5 0	1 18 9
	260	1,287	3,198	1,403	£138 19 8	£8 8 11	£147 8 7

Papers by Guy's Men.

Jordan, A. C., M.D.: Some Points in the Diagnosis of Pulmonary Tuberculosis by the X-rays.—*Lancet*, April 4th, 1914.

Walker, E. W. Ainley, D.M., and another: An Analysis of the Problem of the Minimal Lethal Dose and its Relationship to the Time Factor.—*Lancet*, April 11th, 1914.

Ibotson, Edward C. B., M.D., B.S.: Primary Sarcoma of the Lung.—*Lancet*, April 11th, 1914.

Hunt, G. H., B.M., B.Ch., and another: Observations on Paroxysmal Tachycardia.—*Quarterly Journal of Medicine*, April, 1914.

Layton, T. B., M.S., F.R.C.S.: Tonsils and Adenoids in Children: a plea for fewer operations.—*Lancet*, April 18th. 1914.

Forty, A. Alan, L.D.S.; Some Ideals of Surgery in Dental Operations.—*British Dental Journal*, April 15th, 1914.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—May I, through the medium of your correspondence column, call the attention of the Guy's Hospital Ladies' Association to what some of us, working in the wards, regard as a misdirection of their endeavours? I refer particularly to certain shortcomings in the articles of clothing made for children and infants. A number of dainty and becoming jackets are provided which, practically considered, are entirely unsuitable. They are frequently made of the flimsiest materials, and so constructed as to reach scarcely to the waist, and often are provided with absurdly short sleeves and low-cut necks.

Surely it should be remembered that the first object of any garment is the provision of warmth and covering, and yet these two essentials seem to be commonly left out of consideration.

For the small children the length of garments should be sufficient to cover the legs, as the patients usually lie between linen sheets. A good supply of serviceable flannel or woollen vests, or knitted jerseys would be an inestimable boon, especially in the medical wards, and the number of crying infants might quite possibly be diminished in consequence.

The importance of these, and similar details, must be apparent to those who have experience of the care of children, and I consequently make my appeal in the hope that there may be a prompt and generous response.

Guy's Hospital, Yours, etc.,
London, S.E., X.
April 21st, 1914.

The Dangers of Adrenalin.

Dear Sir,—Two points in reference to Dr. Hammond's notes on adrenalin.

1. I also have seen an attack resembling angina from the injection of the drug. When I was Sir Arbuthnot Lane's H.S. we were trying infusion with 1:100,000 adrenalin solution. On one occasion the solution was not intimately mixed and so the first part put in was a stronger solution than this. The patient, a young woman, cried out, "Oh! my head," and put her hand to that region, remaining then absolutely still and pale for some seconds. She then took a deep inspiration, and said, "I thought I was dying."

2. In his technique for the anæsthetization of the nose Prof. Hajeh adds adrenalin in the proportion of 1:15,000 to his solution which he injects under the mucous membrane. He gives a most solemn warning that no adrenalin should be injected into any elderly person, or one in whom there is any suspicion of organic disease of the heart or blood-vessels, for fear of sudden death. I have been using this technique for eighteen months, and have come to believe that symptoms of faintness or malaise after the injection are more often due to the adrenalin than to the novocaine or other anæsthetic injected.—I am, dear Sir, yours faithfully,

Queen Anne Street, W. T. B. LAYTON.
22nd April, 1914.

Varicella and Herpes.

Sir,—On April 8th I was asked to see a boy aged seven who had come out in spots the previous day. I found him covered with a typical varicella rash. On April 21st I was called to the only other child, a boy of two, to find him with numerous patches of herpes on right buttock and all surfaces of thigh down to the knee. The largest patch was four inches by two and a half inches.—Yours, etc., FRANCIS HEATHERLEY.

Endellion, Rock Ferry,
Cheshire.

The Musical Society.

ACCOUNTS OF CONCERT HELD IN DECEMBER, 1913.

Receipts.

	£	s.	d.
By Tickets and Subscriptions of Honorary Members	23	7	3
,, Balance in Bank	7	0	11
	£30	8	2

Expenditure.

	£	s.	d.
To Music, Augener	6	13	7½
,, ,, Novello	0	17	0½
,, Printing, Straker	4	12	11
,, Tilling...	0	7	0
,, Hire of Piano (2 Concerts)	2	2	0
,, ,, Organ	1	1	0
,, Honorarium of Conductor	10	0	0
,, Incidental Expenses	2	7	3
,, Tuning Piano	0	15	0
,, Balance in Hand	1	12	4
	£30	8	2

It will be seen from this Balance Sheet that the proceeds from the sale of tickets and from the subscriptions of honorary members only just cover the expenses of the concert. It is to be hoped that the support for the coming concert on May 1st will be deserving of Mr. Denis Browne's most interesting programme. Those who heard the last concert will remember that their half-crowns or shillings were well spent and no doubt will make a point of going again; this time they should see that many friends go, too.

The Second Choral and Orchestral Concert of the Session will be held on Friday, May 1st, in the Physiological Theatre, at 8.15 p.m.

The programme will include: Five mystical songs (R. Vaughan Williams) for baritone solo and chorus. Five English folksongs for chorus (R. Vaughan Williams). First performance in London. Blest Pair of Sirens (C. H. H. Barry) for eight part chorus and orchestra. Concert in D minor (J. S. Bach) for two violins and orchestra. Danse Sacrée et Danse Profane (C. Delussy) for pianoforte and strings.

H. Q. F. THOMPSON,
J. J STERLING HILL,
Hon. Secs.

Pass List.

University of Durham.

M.B., B.S. Degrees Conferred.

Roger Paul Ninnis.

Third Examination for the Degree of Bachelor of Medicine: March, 1914.

Materia Medica, Pharmacology and Pharmacy, Public Health, Medical Jurisprudence, Pathology, and Elementary Bacteriology.

Sells, Roland.

Materia Medica, Pharmacology and Pharmacy, Public Health, Medical Jurisprudence.

Richards, Douglas Oliver.

Second Examination for the Degree of Bachelor of Medicine: March, 1914.

Anatomy and Physiology.

Helsham, Christopher Thomas.

First Examination for the Degree of Bachelor of Medicine: March, 1914.

Elementary Anatomy and Biology.

Berry, James Allan.

Royal College of Surgeons of England.

The diploma of membership has been conferred on:—

Philip Savage.

Royal Naval Medical Service.

Examination for Appointments as Acting Surgeons.

At the examination for the Naval Medical Service, held on March 30th and 31st, and April 1st and 2nd, seventeen candidates were successful. The following took the first place:—

Mr. F. C. Hunôt (1,805 marks).

Examining Board in England by the Royal Colleges of Physicians of London and Surgeons of England.

At the Quarterly Examination in Practical Pharmacy, held on April 2nd, the following Candidates were among the approved:—

F. E. R. Laborda. | A. D. Marston.
C. Lambrinudi. | H. Sharpe.
K. J. F. Westman.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Chronic Colitis, its Causation, Diagnosis, and Treatment. By George Herschell and Adolphe Abrahams. (Longmans, Green & Co.)

There is no branch of medicine about which it is more difficult to write than the diseases of the alimentary tract. Symptoms are so many and reliable signs so few, and the relation of cause and effect so inextricably interwoven, that it is impossible to convey a definite, intelligible description of a clinical entity without being dogmatic, and still more difficult to be dogmatic without being inaccurate. "If thy colon offend thee, pluck it out" is the panacea which appeals to the surgical mind; but for the scientific physician who would explain every symptom, to whom every clinical feature is of interest, it is almost impossible to hope for a book that will satisfy everybody, or, indeed, anybody. Clinical observation will so often and inevitably be confused with experimental fact, and occasional symptoms so often and involuntarily emphasised if they happen to fall in with particular theories. The compromise between the scientific treatise and the clinical manual, too, is not always happy, as in this book, where equal space and apparent importance is attached to a theory of hormones and a recipe for making rice-pudding. Apart from these inevitable shortcomings, this is a book which makes pleasant and suggestive reading, and contains not a little valuable information. The chapter on the examination of the fæces is especially instructive, and half the book is devoted to treatment (though ileo-sigmoidostomy is not even mentioned). It is gratifying to know that the mere physician has such a wide selection of therapeutic resources, and the book is to be commended as a praiseworthy attempt to deal with an extremely difficult subject in a rational, common-sense way, and to place its diagnosis and treatment on a proper scientific basis.

Papers Received.—Nursing Times, Hospital, Clinical Journal, M.S. Journal, Polyclinic, London Hospital Gazette, Prescriber, New York State Journal of Medicine, St. Thomas's Hospital Gazette, St. Mary's Hospital Gazette, University College Hospital Magazine, St. Bartholomew's Hospital Journal, Clinical Excerpts.

Marriage.

RENTON–PHILLIPS.—On April 15th, at St. Oswald's, Bradford, Harold Ferdinand Renton, M.D., B.S.Lond., M.R.C.S., L.R.C.P., third son of George Renton, of Harrogate, to Millie, only daughter of the late William Phillips, of Westoe, South Shields.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE first of May saw the inauguration of a new scheme in regard to the distribution of beds in the Medical Wards. Five beds, three male and two female, are now allotted to each of the assistant physicians in the divisions of the corresponding full physician. These beds are to be filled by cases from the assistant physician's own out-patients, or sent to him by outside practitioners, and will be under the care of the house-physician to the corresponding full physician. The assistant physician will have clerks attached to him, and will go round his beds on one afternoon in each week.

The advantages of the scheme are obvious. Suffice it to say that the assistant physicians will now be able to follow up cases in which they are interested after admission, and will, moreover, be able to take in a larger number of cases, for short periods, for purposes of proper investigation. This latter function of the beds will probably be one of the more important, as there must be many cases attending Out-Patients in need of systematic X-ray, blood, and other examinations, but in other respects not absolutely demanding admission into the wards. The change, after the first week or two, will not be likely to embarrass the resources of the take-in house-physician, as there will now be special beds for the out-patient cases (only urgent ones demanding admissions elsewhere), while the remainder can, generally speaking, be kept free for the much larger proportion of cases admitted from the surgery.

We have nothing but commendation for this reform, and we feel that it must be appreciated not only by the assistant, but also by the full physicians, as the latter presumably have hitherto had more beds than they could adequately master in the course of a "three-afternoons-a-week" inspection.

ANOTHER feature of the first of May was the opening of the Baby Room. The room above Clinical has been excellently fitted up for the reception of infants, with five cots and other essential appliances. Dr. Cameron can now, at any rate, boast a nucleus for his much needed Children's In-Patient Department. We understand that at present, attentions in the Baby Room are being directed entirely to questions of feeding, and that all investigations are to be on a thoroughly scientific basis. Five cots seem a pitiably poor provision, but in any case they constitute a beginning, and their very paucity may, perhaps, serve as a stimulus to the realization of our pædiatric dreams.

WE would extend our very hearty congratulations to Dr. Cameron, Dr. Taylor, and

Dr. Hopkins of Cambridge, on their election to the Fellowship of the Royal College of Physicians, and to Mr. T. B. Heaton, Dr. Porter Phillips, and Dr. A. Neville Cox, on their election to the Membership of the same body.

ON another page of this issue will be found an account of the Choral Society's Concert held on May 2nd. The Choral Society is once more to be congratulated, but the Hospital certainly is not; for though the concert maintained a very high standard, it did not receive the full volume of appreciation it deserved, owing entirely to the comparatively small proportions of its audience. We cannot understand how it should come to pass that a society whose performances have won favourable comment in the *Times* and the *Daily Telegraph*, should fail to receive the full support of those who are or should be so intimately concerned with its welfare, as the Staff and Students of the Hospital. It must be very disappointing for Mr. Denis Browne and the members of the Society who have continually devoted a large portion of their scant spare time in preparation for a concert of this kind, to be confronted with rows of empty benches, for however great the enthusiasm of the few may be, the compliment of a full house is surely a more satisfactory reward.

In future we hope to see far larger audiences, and we would remind our readers that, although we may live in an inartistic age and belong to a somewhat material profession, there is never an item in the performances of the Guy's Hospital Choral Society which can really be considered too deep for the appreciation even of the musically-ignorant among us, and that the enjoyment derived from these concerts by all who have attended them is sufficient warrant of their excellence.

THE Residents' going-off Dinner was held on April 30th, in the College dining-room, and was followed by a very successful Smoking Concert, an account of which will be found elsewhere. Mr. Seabrooke was elected President, and Mr. Ryle Vice-President for the ensuing three months.

WE published in our last number a letter relating to the subject of clothing provided for children in the wards. It has produced a reply from the sisters which, while not entirely to the point, raises the question of the advisability or otherwise of broaching such questions in the columns of the GAZETTE. We feel that our correspondent might certainly have acted more wisely in addressing suggestions directly to the officials of the Ladies' Association. We do not believe that there is anyone working in the Hospital, including even the "ignorant X," who is so lacking in appreciation of good work as to consider the achievements of the Guy's Hospital Ladies' Association otherwise than gratefully. No one who has read the reports of the Ladies' Association can fail to appreciate the splendid work they do, and the great assistance, financial and otherwise, they render to the Hospital every year. But even the best organisations are sometimes open to criticism. "X" apparently criticized a certain product, but made no attack or suggestion of an attack on the general work of the Ladies' Association. The GAZETTE, as an organ of reform, is frequently expected to air grievances. The airing of this particular grievance has given offence, for which the GAZETTE offers sincere apology. At the same time it has given the Sisters a further opportunity of expressing their gratitude to the Ladies' Association, while Mrs. Shaw's letter, we think, adequately explains the points at issue.

THE annual meeting of the Guy's Hospital Ladies' Association will take place at 3.30 on Tuesday next, May 12th, in the Court Room. The Countess of Bective will preside, and any lady likely to be interested is cordially invited to be present.

THE Journal of the Chemical Society for April, 1914, contains an appreciation of Matthew Algernon Adams, who died on April 29th, 1914, and who was a Fellow of the Society. Matthew Adams received his medical education at Guy's. First as County Analyst for Kent, and later as Medical Officer of Health for Maidstone, he

gained distinction for a considerable output of original work, and was the inventor of a standard method for the investigation of fat in milk. "The motto of Adams all along was thoroughness, and he certainly succeeded in accomplishing what he undertook . . . His career was a successful example how practically to apply abstract truths of knowledge to every-day things."

Our attention has been called to certain objections to the mats placed at the doorways of the Surgical Wards. No one who has ever pushed a trolley will need reminding of the main objections, and few, we take it, who have ridden on a trolley will be likely to sing the praises of the afore-mentioned mats. Briefly, in fact, the jolting to which they give rise is so severe as to make one wonder whether their advantages are not outweighed by their disadvantages, and when it was pointed out to us that the paving of the court-yard and the length of the colonnade render the possibility of a muddy boot reaching the wards a remote one, and further, that the wiping of boots is, in any case, a refinement rarely practised, we promptly decided to throw in our lot with those who consider the abolition of the mats, and the filling-in of the excavations provided for them, an urgently desirable reform.

Ralph Wingent Memorial Fund.

FIFTH LIST OF SUBSCRIPTIONS.

	£	s.	d.
R. G. Anderson, R.A.M.C. (Egyptian Army), Abassia, Egypt	2	0	0
W. E. S. Digby, West African Medical Service, Kano, Northern Nigeria	1	1	0
V. Glendining	0	5	0
W. Johnson	1	1	0
Henley H. Moyle, Henstridge, Somerset ...	0	10	0
	4	17	0
Previously acknowledged (April 6th, 1914) ...	23	12	0
Total	£28	9	0

H. C. MANN,
P. S. PRICE,
Hon. Secs.

May 5th, 1914.

A Case of Obturator Hernia.

On January 14th, 1914, a woman, æt. 52, was admitted for abdominal pains, and the following history was given :—

Four days previous to admission patient was seized with acute pains in the abdomen and vomiting, and was compelled to take to her bed. She was seen by her doctor who advised her to come up to the hospital. This she refused to do, but the condition becoming worse, she decided to accept her doctor's advice, and was admitted to Martha Ward in a very collapsed condition: pulse, 96; temperature, 96·5; respiration, 20.

The abdomen was tense and very distended in its lower half. The patient was in a critical condition and could only vaguely describe her symptoms. She had passed nothing per rectum for four days, but on January 19th, five days previous to admission, there was a normal motion; the vomit was fæcal in character, and this the patient herself had noticed for two days. She also had pain in the left leg, but she was very indefinite as to its locality. Mr. Fagge operated; a spinal anæsthetic was given; a median laparotomy incision was made and the cause for obstruction searched for. This was discovered in an incomplete hernia in the left obturator canal. The strangulated loop of intestine was carefully withdrawn and was found to be deeply congested, but apparently quite viable. It was, therefore, returned to the abdomen. The canal was left patent, Mr. Fagge observing that they were of the same size on both sides. The patient made an uninterrupted recovery.

According to Keen (vol. iv., p. 97) this rare form of hernia was first described by Arnaud de Rousel in 1720, and only 200 cases have been reported up to the present. On looking up the Reports of Guy's Hospital I find there has been no case recorded since reports have been indexed.

The diagnosis has rarely been made until strangulation had occurred. The position and relations of the obturator canal explain the difficulties in diagnosis. The obturator foramen is closed by the membrane except in its upper part where there is an opening for the passage of the obturator nerves and vessels, and through this opening the hernia passes on into the thigh, and before there is any visible tumour in the thigh it must push with it or to one side the obturator internus muscle which bounds the foramen on its pelvic side, and the obturator externus and the pectineus muscles which cover it externally. The pain referred to the inner aspect of the thigh—known as the Howship-Romberg sign—is due to the pressure on the obturator nerve by the tumour in the canal. It has been pointed out by Schwartzchild that this sign cannot always be relied upon, since it has been present in other conditions as well.

R. A. H.

A Case of Intestinal Obstruction following General Peritonitis.

Resection of Intestine on two occasions. Recovery.

E. P., a boy, æt. 14, after a week's history of acute abdominal pain accompanied with some vomiting, was admitted into Lazarus under Sir Arbuthnot Lane on October 8th, 1913. Pulse, 104; temperature, 100·6° F.; respiration, 40.

On the same day he was operated on by Mr. J. G. Saner. A perforated appendicular abscess with general peritonitis was found to be present, an appendicectomy performed, and the abdominal cavity drained. Patient's condition did not improve, his temperature, pulse, and respiration remained much above normal, and he was again operated on by Mr. Saner on October 21st, when a large pelvic abscess was opened up and drained, a considerable quantity of pus being evacuated. Patient's condition gradually improved until October 29th, when he was suddenly attacked with acute abdominal pain and vomiting in progressive stages, showing typical signs of acute obstruction.

Mr. Saner operated at once, and an obstruction was found at the lower end of the ileum; this was due to adhesions in the region of the appendix. An ileostomy was performed, a Paul's tube being sewn in and the intestine drained, after which the patient suffered from considerable shock for three days, his temperature falling to 95·4° F., and pulse rate 128.

On November 2nd patient began to improve rapidly, although he still suffered some pain, and, owing to much wasting, Mr. Saner, with Mr. C. H. Fagge advising, operated again on November 7th. An incision was made through the left rectus. The intestines were much matted together; they were traced to the ileostomy, and the drainage opening cut away from the abdominal wall, part of the ileum was resected, and a lateral anastomosis performed. It was impossible to stitch the wound up owing to the unsatisfactory condition of the abdominal wall, and both wounds were left to granulate up.

The following day patient was in a very critical condition, suffering greatly from shock (temperature, 95° F.; pulse, 112). His condition remained grave until November 12th, after which he improved rapidly. During convalescence he had several attacks of colic. his appetite became enormous, and he put on much weight; temperature and pulse remained normal, the wound granulated up, and after a remarkable recovery he was discharged quite relieved on December 10th, 1913, having been in hospital for nine weeks.

On April 2nd, 1914, patient was suddenly attacked with acute abdominal pain with vomiting of much greenish coloured material, and he was again admitted into Lazarus on April 4th suffering from acute obstruction. Temperature, 99·4° F.; pulse, 120; respiration, 24.

On admission his abdomen was much distended and somewhat rigid, especially to the right of the umbilicus, and generally tender on palpation; visible peristalsis was present. He vomited over half a pint of fæcal material, his stomach was washed out and over three pints of fæcal matter removed. The same evening he was infused with saline and again operated on by Mr. Saner under a spinal anæsthetic. On opening the abdomen the absence of adhesions was remarkable considering that four wounds in the abdominal wall communicating with the peritoneum had suppurated; the small intestine was much distended, its walls congested and very œdematous, presenting typical signs of lymphatic engorgement, and free fluid was present in the abdomen. Beyond the region of the previous anastomosis the intestines were collapsed. The anastomosis was firmly adherent to the posterior abdominal wall in the region of the left iliac fossa; here a leakage was noticed due to recent ulceration with much laceration of the intestinal wall.

The bowel contents were immediately milked back up the intestine and a small clamp applied; a similar clamp was placed below, and the upper portion of the intestine, about three inches in length, resected, protective pads being used, the latter being necessary because it was impossible to deliver the lower portion. The opening in the upper segment was invaginated with thread, the lower opening being similarly treated in its fixed position. A collapsed portion of free small intestine, distal to the fixed portion, was then delivered and a lateral anastomosis performed between it and the upper segment. This was rendered very difficult owing to the hæmorrhagic and non-resistant condition of the intestinal wall; the abdominal wall was now stitched up and a rubber drain inserted.

Patient stood the operation well, although he suffered from considerable shock for two days, during which period, owing to fæcal vomiting, his stomach was washed out on three occasions, about three pints in all being removed. On April 7th his bowels were open slightly for the first time, and although the wound suppurated for several days, his condition gradually improved. The stitches were removed on April 15th, and the patient made a remarkable and uninterrupted recovery, and was discharged quite relieved on April 29th.

This case is interesting in several ways, viz.:—

1. From the long interval between the onset of symptoms and operation for general peritonitis.

2. For recovery from such advanced general peritonitis.

3. For recovery after two operations for resection of intestine within six months.

R. C.

(I am indebted to Mr. C. H. Fagge and Mr. J. G. Saner for their kind permission and help in reporting this case.)

Guy's Hospital.

Church Council's Report for the Year ending Easter, 1914.

The Chapel Committee have pleasure in presenting the following report for the year ending Easter, 1914.

The Services in the Chapel have been carried on as usual during the past year, and it is worthy of note that, in spite of the ever changing list of communicants, the Holy Eucharist has been celebrated each day, with but one exception.

Shortly after Easter, 1913, the Rev. C. Luxmoore-Ball resigned his appointment as Acting-Chaplain to become Rector of Holy Trinity Church, Edinburgh. The Committee desire to record their deep appreciation of his sympathetic and unstinted work and to wish him God speed in his new field of labour. The Chaplain appointed the Assistant Acting-Chaplain (the Rev. A. E. Popham), to take his place, and he was helped in a part of the work by the Rev. W. J. Jobling, until July 6th, when the Rev. Mark Sutton, from New Zealand, became Assistant Acting-Chaplain. The last named resigned and in December was appointed to the living at S. James's, Camberwell. Since that time the Rev. W. J. Beechey (Chaplain to the Lambeth Infirmaries) has given a part of his time to the work. The Committee beg to thank these gentlemen for their assistance. During the whole of the year considerable help has been given by the College of S. Saviour, for which the Committee are very grateful.

The Committee have also to thank Mr. Denis Browne for his careful and energetic oversight of the Chapel music, and for the recitals he has given after Evensong from time to time.

In accordance with a resolution passed at the last meeting the seventh mosaic panel, The Annunciation, has been placed in position.

The Balance Sheet for the year ending December 31st, 1913, showing a credit balance of £8 13s. 11d., was read and adopted.

Change of Address.

H. P. Warner, M.B., B.S., to "Rydal," Woodford Green, Essex.

P. W. L. Camps, F.R.C.S., to Old Udney Cottage, Kingston Lane, Teddington.

C. H. Stainer, L.D.S., from 22, Twyford Avenue, West Acton, to P.O., Lydenburg, South Africa.

T. E. Henderson, L.D.S., to 143, Eastgate, Louth, Lincolnshire.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Residents' Smoking Concert.

DEAR SIR,—Will you kindly allow me to express the thanks of the Residents to those who helped to make the Smoking Concert a success. Mr. G. Seabrooke took a great amount of trouble in arranging the concert, besides helping in the programme himself, and Mr. Capper and Mr. Cuthbertson kindly gave their services. We would like to thank these and the other hospital artistes who contributed largely to the success of the evening, as well as our chairman, Dr. A. Allport, Dr. Jackson Lang, and our ever-helpful poster-artist, Mr. Stanley Cock.—Yours truly,

WILLIAM ROBINSON.

Guy's Hospital,
London, S.E.
May 5th, 1914.

SIR,—Will you kindly allow me to make use of your columns in order to express my gratitude to the Guy's Hospital Nurses' Suffrage Society for the opportunity I enjoyed on April 21st, of hearing Miss Maude Royden speak. The ability and earnestness evinced by her speech, as well as the points raised and the information given, heightened (if possible) the immense admiration I have always felt for my own sex. Her admirably chosen allusion to the woman of Jane Austen's day and of man's attitude towards her then brought out vividly the tremendous advance women have made since then—partly, it is to be presumed, through men's fighting her battle for her now-a-days, partly through her own signal success in doing so herself unaided by the Parliamentary vote. We were even told of one woman who by influencing public opinion obtained an alteration favourable to the mother in the law regarding the custody of the children in a case where a woman leaves her husband.

It would take too long to deal here with all the points at which Miss Royden's speech was open to attack; suffice it to say that the effect produced was that of very strongly confirming my already strong convictions as an anti-suffragist.—Yours faithfully,

DOROTHY H. SPALDING.

Superintendent's House,
Guy's Hospital.
April 22nd, 1914.

DEAR SIR,—Referring to the letter from "X" in the last number of the GUY'S HOSPITAL GAZETTE, we are most anxious to make it understood how very much the work of the Ladies' Association is appreciated. Sisters working in the wards are exceedingly grateful for the clothing so kindly sent year after year.

It is quite evident that "X" is absolutely ignorant of the facts of the case, and it would have been wiser to have taken the trouble to understand the matter before writing such a letter. The writer might then have learnt that each Branch of the Ladies' Association works for its own special wards, the Sisters of which are nvariably consulted before the commencement of the year's work. A great deal of trouble is taken in order to find out what garments are most needed, and a great deal of trouble is taken by the various secretaries to obtain those garments from the members of their branch.

I should be glad if you would kindly insert this note in your next issue.—Yours faithfully,

HILDA M. EDMONDS,
On behalf of the Sisters.

Guy's Hospital,
London, S.E.
April 29th, 1914.

DEAR SIR,—In the last issue of the GAZETTE a correspondent criticized some of the garments made by members of the Ladies' Association. I do not know if your correspondent is familiar with the organization and methods of the Association, but if not, may I assure her, or him, that every effort is made to secure that the right kinds of garments are contributed. The secretaries of local branches working for specific wards always communicate with the Sister at the beginning of each season, and they do their utmost to get the special needs of each ward supplied. With a membership of over 1,500, it is almost impossible to avoid having a few garments that may not be very practical. If your correspondent will write to me privately, I shall be only too pleased to discuss the cases in which it is thought improvement might be made. May I also, through your columns, take this opportunity of asking all those working at the Hospital to let the officers of the Ladies' Association know when they see any way in which its services may be extended or improved for the benefit of the patients.

Yours faithfully,
MAY H. SHAW,
Hon. Sec.

Guy's Hospital
Ladies' Association,
64, Harley Street, W.,
May 4th, 1914.

The Smoking Concert.

The Residents' "Smoker" was held in the College Dining Hall, on Thursday, April 30th, at 8.30 p.m., following the "Going-off" Dinner. Dr. A. Allport was in the chair, and there was a fairly large audience, but it was noticeable that very few of the junior men were present. The Concert was a great success from beginning to end, and all the items were applauded noisily and enthusiastically. The organizers of the Concert, Messrs. W. Robinson and G. Seabrooke, are to be heartily congratulated on the success of the evening. They provided us with quite the best programme we have had at a "Smoker" in recent years, and it was not their fault that some of the artistes who had promised their help failed to put in an appearance.

Dr. Allport, in opening the proceedings, reminded us that it was just twenty-five years since he and Dr. Jackson Lang, who also came down, had first started these concerts.

The Programme was as follows:—Mr. H. Q. F. Thompson (song); The Rag-Time Medicos (Messrs. Morgan and Fasken in selections from their répertoire); Mr. Parry-Jones (songs); Dr. Jackson Lang (humorous stories); Mr. H. N. Eccles (songs); Mr. Chas. Capper (whistling); Mr. G. Seabrooke (songs); Mr. Cuthbertson (songs); Mr. A. H. Harkness (songs).

Mr. Seabrooke's singing, already well known to most of the audience, was quite the best item, and was vigorously encored. The Rag-Time Medicos repeated their success of last Christmas. Mr. Chas. Capper's whistling is a revelation of the possibilities of that despised and neglected art.

A very jolly evening was brought to a close amid considerable noise and hilarity at about 12 o'clock.

Pass List.

Royal College of Physicians.

At the ordinary quarterly *Comitia* of the Royal College of Physicians, held April 30th, the following members of the college were among those elected Fellows:—

H. C. Cameron, M.D. Camb.
F. G. Hopkins, M.B. Lond.
J. G. Taylor, M.D. Camb.

The following were among those admitted to the Membership:—

A. N. Cox, M.D. Lond.
T. B. Heaton, B.M. Oxon.
J. G. P. Phillips, M.D. Lond.

The following candidates were among those to whom Licences to practise physic were granted at this meeting:—

F. D. Annesley.
C. Dean.
I. F. Diay.
M. Z. Hanafy.
F. W. Lawson.
E. G. Martin.
P. J. F. L. R. du Vergé.
P. Savage.
H. Sharpe.
L. M. Smith.
S. B. Venugopal.
H. P. Whitworth.
A. Wills.

Society of Apothecaries of London.

At the Primary Examination held on April 6th, 8th, and 9th, the following candidates passed in the subjects indicated:—

Anatomy.—D. V. Halstead.
Physiology.—D. V. Halstead, W. J. Walters.

The Toxæmias and Septic Infections of the Newly-born.

CLINICAL LECTURE BY DR. CAMERON.

GENTLEMEN,—The infant nursed at his mother's breast enjoys in the first days of life a two-fold protection which is lacking in the artificially fed child. In the first place, he derives from the colostrum a supply of immune bodies which are capable of conferring protection until the development of his own defensive powers (Lane-Claypon); and in the second place, the bacterial flora of the intestine tends to establish itself in a constant and well-controlled manner, and the change from the sterility which obtains at birth to the fully-developed bacterial picture is accomplished normally and without disturbance.

In the intestine of the artificially fed child matters may not proceed so smoothly, and in the absence of the antagonism of the normal bacterial content, pathogenic organisms may gain a foothold and develop. Especially is this the case in premature infants, and it is common experience that the various manifestations of the toxæmias of the newly born — icterus neonatorum, eclampsia and trismus neonatorum, melæna neonatorum, and septic diarrhœa—are all more frequent in children born before full time. The explanation of this predisposition lies partly in the increased vulnerability of the intestinal wall, which acts as a less efficient barrier to bacteria and their toxins, as experiments by Czerny show, partly in the circumstance that a premature child is often saturated with the syphilitic or other toxin, and partly, perhaps, in the more frequent failure of breast nursing because of the failure of the medullary sucking reflex. At any rate, it is certain that prematurity is itself a strong predisposing cause of sepsis, and that syphilitic infants are especially liable to suffer severely.

Although the alimentary canal is the chief source of infection, it is probably not the only source. A general infection may take place from catarrhs of the respiratory tract and of the urinary tract or from lesions of the skin or umbilicus. It is probable, however, that inflammation of the umbilical stump is more often the result than the cause of a general infection. It is more doubtful what part is played by infection of the mother and maternal sepsis in general.

Symptoms of the toxæmias of the newly born.—The symptoms are of very varied character. Although for the sake of clearness they will be described separately, in actual practice they frequently occur in various combinations. Buhl's disease and Winkel's disease, which to-day still find a place in the text-books of Children's Diseases, are now of historical interest only. They do not represent independent specific disorders, but particular combinations of toxic manifestations which were prominent in the cases and epidemics described.

ICTERUS NEONATORUM.

Icterus neonatorum in mild degree is so frequent that it has sometimes been claimed as a physiological rather than a pathological symptom. It commonly appears upon the second or third day of life, and in mild and uncomplicated cases—and these are an overwhelming majority—declines during the second week.

In rarer cases the icterus is combined with other and more grave symptoms: profuse and septic diarrhœa, eclampsia, or hæmorrhage. In these cases there is profound toxæmia, often with high pyrexia and coma.

Diagnosis.—Icterus neonatorum is to be distinguished from the severe and progressive jaundice which results from congenital obliteration of the bile ducts, or from syphilitic cholangitis. In the congenital defect, the absence of other manifestations of toxæmia neonatorum, combined with a very severe grade of jaundice persisting from the first few days of life, is sufficient to suggest the true diagnosis. In syphilis other characteristic symptoms are likely to be present. When jaundice is due to infection from the umbilicus and extension by the umbilical veins to the liver, there is usually a marked local reaction at the umbilicus.

Prognosis.—Of all the forms of toxæmia of the newly born, that which is marked only by uncomplicated jaundice offers the best prognosis. The mortality in such cases is trivial.

Treatment.—In breast-fed infants no treatment is necessary in uncomplicated cases. In bottle-fed infants food should be sparingly administered for some days, while water flavoured with saccharin is given freely.

ECLAMPSIA NEONATORUM.

A less usual form of toxæmia is seen in cases in which the symptoms are confined to the nervous system. Unrest, rigidity, and spasticity of limbs, trismus, frequently repeated twitchings of the limbs, face, and eye muscles, especially upon stimulation, or actual convulsions, are pro-

minent symptoms. A light tap on the child's breast will often produce a general twitch of the whole body. The rigidity of the facial musculature gives a fixed expressionless appearance; often the jaws are fixed as in true tetanus.

A case which illustrated the symptoms well is at present in Clinical, and is reported by Mr. Lane Roberts.

Diagnosis.—The condition has to be separated from convulsions of the newly born due to trauma. In these, paresis or paralysis of face or limb, a cerebro-spinal fluid which is blood-stained, the history of a difficult and prolonged labour, bruising, and ecchymosis of the scalp or eyelids, or other injury, may suggest the correct diagnosis. In convulsions due to toxæmia a degree of icterus is often present at the same time.

Premature children suffer often from toxæmia, seldom from trauma. Convulsions due to spasmophilia, that is to say, the usual convulsions of infancy associated with a faulty dietary and often with rickets, never occur at birth, and hardly ever in breast-fed infants. Even where trismus is the prominent symptom, the condition is seldom due to true tetanus. In doubtful cases a smear from the umbilicus must be examined for the tetanus bacillus.

Prognosis.—The prognosis, though less uniformly favourable than that of uncomplicated icterus, is still good. Only in severe cases with persistent convulsions, high pyrexia, and unconsciousness need there be fear of death. Cases in which convulsions come on after an interval of some days are of better prognosis than those which begin soon after birth, presumably because the infection is less violent and more controlled. The prognosis for the later life is, perhaps, more doubtful. It is certain that psychical disturbances and epilepsy develop with greater frequency in infants in whom there were convulsions at birth.

Treatment.—The infant should be kept under the influence of chloral for some days. Doses of one grain may be given every two or three hours by mouth, or double doses by the rectum. A hot pack is often soothing. Meanwhile the child should be kept very warm, and if artificially fed, water sweetened if necessary with saccharin given freely, while food is only allowed in minimal amounts until the cessation of the convulsions. All unnecessary handling of the child should be avoided, and he should lie quietly in a darkened silent room.

MELÆNA NEONATORUM,

or the hæmorrhagic disease of the newly born.

Symptoms.—Septic bleeding in the great majority of cases takes place from the bowel only. With more profound toxæmia, hæmatemesis, purpura, vaginal bleeding, oozing from the umbilical cicatrix and from other accidental wounds of the body, may occur. Melæna is said to occur in about one case in every thousand infants. Infants with congenital syphilis show a well-marked tendency to suffer from this type of disorder.

Illustrative case.—A premature infant born in "the District" was brought to the Out-Patient Depart. on the ninth day of life. Melæna had begun three days before. Because of the comparatively long interval between the birth and the hæmorrhage, a comparatively hopeful prognosis was given. The temperature was normal. There was no jaundice, convulsions had not occurred, and diarrhœa was absent. Three days later a profuse syphilitic eruption appeared, and the infant died in the course of the next week.

Prognosis.—The prognosis is always grave. Probably about 50 per cent. of cases with melæna only survive. With hæmorrhage from other sources as well the condition is usually fatal. If syphilis is present the prognosis is well nigh hopeless. Prematurity also greatly diminishes the chances of recovery. If an interval of some days intervenes between the hæmorrhage and the birth, the prognosis is better. High pyrexia, coma, convulsions, jaundice, and diarrhœa indicate a severe and probably fatal toxæmia. A case illustrating these points well was recently in Miriam, and is reported by Mr. Yorke Moore.

Diagnosis.—True melæna must be distinguished from melæna spuria, in which blood is swallowed from a "cracked" nipple. Hæmophilia occurs in male infants, although the condition is one of great rarity. A family history of the condition is always obtained. Intussusception does not occur in the newly born.

Treatment.—5 c.c. of fresh horse serum should be injected subcutaneously, or 20 c.c. of Merck's gelatine. The site of injection should be painted with collodion to control oozing from the spot. Striking results are recorded from the transfusion of human blood into a vein. Bleeding from the umbilical stump should be dealt with by touching the cicatrix with the actual cautery, or it may be painted with adrenalin solution

(1 per cent.), or with horse serum applied locally. In bleeding from the vagina, from the nose, or from wounds, tampons of gauze soaked in adrenalin solution or horse serum may be applied. Internal medication is without avail.

All foods should be withheld for forty-eight hours, while water sweetened if necessary with saccharin is given by the mouth, or saline solution by the rectum.

Septic Diarrhœa.

The cases in which acute diarrhœa is added to the other symptoms of intoxication described above, are especially serious. When, from the first days of life, the evacuations of the bowel are watery and slimy, and have a powerful putrefactive odour, the condition is always grave. When great restlessness, coma, convulsions, jaundice, hæmorrhage from the bowel, and rapid emaciation are present in addition, the result is usually fatal. If breast milk cannot be obtained, recovery may be despaired of.

Pemphigus Neonatorum. Dermatitis Exfoliativa Neonatorum.

Two diseases of the skin occasionally met with may be described in this connection —pemphigus neonatorum and erythrodermia disquamativa. Neither is usually accompanied by a generalized infection, but each is the direct result of a septic infection of the skin of the newly born.

Pemphigus neonatorum is rarely seen in this hospital. Dermatitis exfoliativa is comparatively frequently met with. A very typical case was admitted to Miriam, under me, with Mr. Sherris as clinical. Both disorders result commonly from the direct inoculation of the tender skin of the child with staphylococci and streptococci. Considerable epidemics have been known to occur in the practice of a particular midwife, and they have been shown to be due to a neglected whitlow on her finger, or to some other similar source of infection. In other cases other children in the family have suffered from impetigo contagion at the time of the birth.

It is well to remember how sensitive and vulnerable the skin of the newly-born is. The infant has been immersed in the amniotic fluid, and any rough friction in the attempt to remove the vernix caseosa, or in drying the infant after the first bath, readily dislodges the superficial epithelial layers. In such a case, in the first few days of life, before the organism has developed defensive powers against bacterial invasion, there may be a very rapid and alarming inflammatory reaction.

The newly-born infant should be dried with the utmost gentleness, and any friction should take place between the nurse's hand and the towel, not between the towel and the infant's delicate skin.

Diagnosis.—Dermatitis exfoliativa can hardly be mistaken. The intense congestion and redness of the skin, off which the superficial epidermal layers peal in large flakes, is characteristic. The superficial layers of epithelium adhere to the exposed deeper layers like ragged and tattered scraps of moist tissue paper. The whole area of skin may be involved.

Pemphigus is to be distinguished from a syphilitic bullous eruption. The syphilitic pemphigus involves the soles of the feet and the palms of the hands, the true pemphigus does not. The bullæ in the syphilitic variety seldom attain so large a size.

Prognosis.—The prognosis is good. I have not yet met with a case of exfoliativa dermatitis which has ended fatally. The treatment of pemphigus is to prick the bullæ, and to powder the exposed surface freely with boric acid. In dermatitis exfoliativa, ointments and pastes (boric acid or zinc) are indicated.

Notices.

Course of Lectures in Dental Materia Medica, Pharmacology, and Therapeutics.

Summer Session, 1914.

Mr. Dowsett will deliver these lectures in the Physiological Theatre on Fridays at 4 p.m., commencing on Friday, the 8th May.

Guy's Hospital,
27th April, 1914.

Royal College of Surgeons of England.

THE TRIENNIAL PRIZE.

Consisting of The John Hunter Medal executed in Gold to the value of Fifty Guineas, or, at the option of the successful Author of the Dissertation, of the said Medal executed in Bronze, with an honorarium of Fifty Pounds.

The subject for this Prize is:—"The Human and Comparative Anatomy and Physiology of the Cerebellum."

JACKSONIAN PRIZE.

The amount of the Dividend, about £14, received from the Trust. The subject for the Prize for the present year, 1914, is:—"The Pathology, Diagnosis, and Treatment of Trigeminal Neuralgia."

The subject for the Prize for the ensuing year, 1915, is:—"Congenital Dislocations of the Joints, their Pathology and Treatment."

The Prizes are to be written for under the following conditions:—

Candidates to be Fellows or Members of the College, not on the Council.

The Dissertations to be *typewritten* in English, and the number and importance of original facts will be considered principal points of excellence:—*cited cases to be placed in an appendix.*

Each Dissertation to be distinguished by a motto or device; and accompanied by a sealed envelope containing the name and residence of the Author, and having on the outside a motto or device corresponding with that on the Dissertation.

The Dissertations to be addressed to the Secretary at the College.

The Prize Dissertations and every accompanying drawing and preparation will become the property of the College.

Those Dissertations which shall not be approved, with their accompanying drawings and preparations, will upon authenticated application within the period of three years, be returned together with the papers, unopened, containing the names and residences of the respective Authors.

The unapproved Dissertations which shall remain three years unclaimed, with their accompanying drawings and preparations, will become the property of the College; at which period the papers containing the names of the Authors will be burnt, unopened, in the presence of the Committee.

The Dissertations for the Triennial Prize must be delivered at the College not later than 4 o'clock p.m. on the 31st of December, 1915.

The Dissertations for the Jacksonian Prize for the present year, 1914, must be delivered at the College not later than 4 o'clock p.m. on Thursday the 31st of December next.

The Dissertations for the Jacksonian Prize for the ensuing year, 1915, must be delivered at the College not later than 4 o'clock p.m. on Friday the 31st of December, 1915.

S. FORREST COWELL,
Secretary.

2nd April, 1914.

Presentation Day, University of London.

Wednesday, May 13th, 1914.

A few tickets for this Ceremony have been forwarded for the use of Guy's Students; these will be given to the first applicants at the Medical School Office.

Guy's Hospital,
May 6th, 1914.

Guy's Hospital Past and Present Nurses' League.

The Sixth Annual Dinner and the Twelfth Annual Meeting of the Guy's Hospital Past and Present Nurses' League was held in the Nurses' Home on Friday, April 24th, 1914. About 110 Past Members and Sisters sat down to dinner in the dining-hall, the tables looking very pretty with their floral decorations of yellow daffodils, and the Home Sister, Miss Marion Gratton, is to be congratulated upon the very successful way in which everything was carried out.

Among those present were:—The Matron, the Vice-President, Miss Swift, Mrs. Andrews, Mrs. Browning Mrs. Cameron, Mrs. Flower, Mrs. Game, Mrs. Goule, Mrs. Hinchliff, Mrs. E. C. Hughes, Mrs. Knight, Mrs. Lewis, Mrs. Meredith, Mrs. Poolman, Mrs. Reynolds, Mrs. F. Shaw, Mrs. G. Smith, Mrs. Thorpe, Mrs. P. Turner, Mrs. Willox, Mrs. Wood, Mrs. Wright, Miss Atkey, Miss Beard, Miss E. Bell, Miss Blayney, Miss Bryan, Miss M. Crampton, Miss A. Davidson, Miss Finnis, Miss Finnemore, Miss Hoadley, Miss Hyland, Miss Jolley, Miss Lewin, Miss E. Newton, Miss A. M. Phillips, Miss Rowell, Miss F. Sheldon, Miss Seaman Brown, and Miss K. Yeates.

After dinner, tea and coffee were served in the Hall, and many other members who were unable to be present at the dinner joined the party, and many old friendships were renewed.

The Meeting was held in the large Recreation Room, Miss M. Atkey, the Matron of the Royal Gwent Hospital, Newport, taking the chair. In her opening speech Miss Atkey said how splendid it was for old Guy's Nurses to have such a League as this, when everyone was talking of union and organisation. Guy's was before the times in founding a Past and Present Nurses' League, and it was now not only one of the oldest, but also was one of the largest, having a membership of over 1,100. Past Members who were working abroad and in the country who were unable to be with them that evening would be interested to read of their re-union in the nursing papers. She urged upon Members the necessity of keeping ahead of things, but in their endeavour to do so they must realise their duty to their profession as a whole, and they should not leave behind them the fine traditions of the older nurses who were devoted to their patients, but did not realise their social obligations.

The minutes of the last Annual General Meeting were then taken as read, and signed, and the Matron, the Hon. Secretary of the Nurses' League presented the report of the year's work. Between 80 and 90 members had been transferred to the Past Members' Section during the year. 170 week-ends and days off had been spent at the cottage, and 6 Past Members

had also stayed there. 1,252 short visits for tea, etc., were paid, being 218 more than last year. 3,002 volumes had been taken out of the Nurses' Library, and about 30 new novels and 32 new medical books had been added.

The Musical Society had given a very successful concert in December, and was able to pay all expenses, and also to have a little balance in hand. The Debating and Literary Society had held four debates during the winter. The Swimming Club had started water polo, and a new net had been put up. The Nurses' Tennis Club was again successful in carrying off the Silver Challenge Cup offered by the *Nursing Times* for competition among the Nursing Staffs of the London Hospitals and Infirmaries, and they hoped that they would be successful this year, when it would remain the property of the Club. A new tennis court had been made at the Cottage at a considerable expense, but it was much appreciated by the members. The Hockey Club had played some games at Southwark Park during the season, but owing to the difficulty in getting a sufficient number of players off duty together it was feared that this section would have to be abandoned.

The Photographic Society was still very enthusiastic, and the exhibition of pictures was a credit to the members. There were several new members, and it was hoped that another year more pictures would be sent in "as the entire work of Exhibitors."

The Second Exhibition of Needlework was also very successful, and although there were not so many exhibits, the work shown was of a very high standard, and Mrs. Burgwin had great difficulty in making the awards in some of the Classes.

The seventh edition of the Nursing Guide and Register was sent out to members last July, and the Supplement was distributed in December, a new departure being made this year by the insertion of the marriages of League Members. It had since been suggested that the insertion of births would also be of interest to members, and such notices are requested for the supplement to be sent out next December.

A course of Post-Graduate Lectures had been given, and the pamphlets would be sent out to subscribers as soon as possible.

In the absence of Mrs. Fagge, the Hon. Treasurer, the Matron presented the statement of accounts for the year. They had again this year been able to meet the current expenditure out of the members' subscriptions, and also to pay a sum of £150 off the debt on the Cottage, which now was reduced to £1,350. They had also paid for the making of a new tennis court at the Cottage. A sum of £100 had been placed on deposit at the Bank to help defray the cost of building some additional rooms at the Cottage this year, and the balance of the current account amounted to a little over £13.

The result of the ballot for the election of Present Members was next declared as follows:—

Swimming Club.—Sister Olive and Nurse Hook.

Tennis Club.—Sister Lydia and Nurse Rowan.

Nurses' Library.—Sister Job and Nurse Brennand.

Debating Society.—Sister Light and Nurse Wilson.

Nurses' Choral Society.—Sister Ruth and Nurse Drower.

Hockey Club.—Sister Naaman and Nurse Looker.

Photographic Society.—Sister Addison and Nurse Webster.

Miss Swift, who was enthusiastically received, congratulated the members upon the satisfactory condition of the League, and proposed that the election of three Hon. Members of Council, the Countess of Bective, Mrs. Hale White, and Mrs. Craig, should be confirmed.

The question of affiliation with the National Union of Women Workers was next discussed, and it was agreed on the proposition of Miss F. Sheldon, seconded by Miss E. Newton, that the Guy's Nurses' League should apply for affiliation, because, with the question of State Registration coming before the public, it was important that they should keep in touch with outside organisations.

The Meeting was brought to a close with various votes of thanks to the officers, after which a selection of vocal and instrumental music was given by some of the Present Members, and many of the visitors who had not already done so inspected the needlework and photographic exhibitions in the adjoining rooms.

THE PHOTOGRAPHIC EXHIBITION.

The Eleventh Exhibition of the Nurses' Photographic Society was opened on Friday, April 24th, in the afternoon in the presence of The Countess of Bective, Lady Fripp, Mrs. Cosmo Bonsor, Miss E. Bonsor, Mrs. French, Mrs. Rowlands, Mrs. Symonds, and other Hon. Members.

The photographs, numbering over 190, were placed on screens covered with brown canvas, edged with a narrow piece of dark wood, and divided into panels, which proved an effective setting to the exhibits. Mr. F. T. Hollyer again kindly judged the photographs, and expressed himself very pleased with the progress made by the Society, and urged the members to have their photographs enlarged so as to show them to better advantage.

Mr. Hollyer made the following awards which were placed at his disposal by some of the Hon. Members:

Class A.—1st Prize, "The Duck House," Sister Addison. 2nd Prize, "Through the Woods," Miss J. Paterson. 3rd Prize, "Feeding the Ducks," Miss Oldendorff. Highly commended, "A Happy Family," Miss I. Stones.

Class B.—1st Prize, "A Temple, Benares," Miss K. Hodgkinson (India). 2nd Prize, "Clouds and Floods,"

Nurse Thackray. 3rd Prize, "Waiting," Miss E. V. Smith.

Class C.—1st Prize, "Sandsend, near Whitby," Miss Stansfield. 2nd Prize, "A Portrait by Flashlight," Sister Addison. 3rd Prize, "The Duck Pond," Miss K. B. Webb (India). Highly commended, "Silver Birch," Miss Stansfield; "Happy as a King," Sister Rebecca Ford.

Special prize for the best picture in the Exhibition, and special prize for best picture sent in by member now working in the Hospital, was awarded to Sister Addison for photograph entitled "The Duck Pond."

Several photographs were sent in by Miss Smith marked "not for competition," one entitled "Near Loughton" being specially commended.

Among the exhibits were some interesting photographs of South Africa and Japan sent in by Miss M. I. Burdett; of Canada, by Miss K. B. Webb; of the Gold Coast, by Miss A. Park; of the Pyrenees, by Miss C. Mitford; of Normandy, by Miss E. R. Gill; and of China, by Miss E. Haward and Miss A. Zagallo.

NEEDLEWORK EXHIBITION.

The Second Exhibition of Needlework was opened simultaneously with the Photographic Exhibition. There were between sixty and seventy exhibits sent in by Past and Present Members, consisting of Plain Needlework, Patching and Darning, Drawn Thread Work, White Embroidery, Coloured Embroidery, Hardanga Work, Crochet, Knitting, and Church Embroidery.

The exhibits were arranged in glass cases and on tables by Sister Naaman, Miss New, and prizes were placed at the disposal of the judge by several Hon. Members of the Nurses' League. Miss Burgwin, the Inspector of Special Schools under the L.C.C., again kindly judged the work, complimented the Members on the excellency of the work shown, and made the following awards:—

Plain Needlework.—Nurse Staines, 1st prize; Nurse Sutton, 2nd prize; Nurse Carr Hill, highly commended.

Plain Needlework (Muslin).—Miss E. Hall, very highly commended.

Patching.—Nurse Edith Hope, prize.

Darning.—Miss E. Hall.

Hardanga.—Nurse Windley, prize; Miss Victoria Jones and Nurse K. Hodgkinson (India), very highly commended.

White Embroidery.—Sister Naaman (Miss K. New) prize; Nurse Boys, highly commended.

Coloured Embroidery.—Nurse Knight-Law; Sister Patience (Miss Hutton) highly commended.

Crochet.—Nurse A. L. Witchell, prize; Nurse Pace, very highly commended; Sister F. E. Brown (Kirkby Lonsdale), highly commended.

Knitting.—Nurse Carr Hill, prize.

Lace Darning.—Nurse K. Hodgkinson, very highly commended.

Drawn Thread Work.—Nurse Hills, highly commended.

Guy's Hospital.

Chapel Fund Account.

Statement of Receipts and Expenditure for the Year Ended December 31st, 1913.

Receipts.

January 1st, 1913.	£	s.	d.	£	s.	d.
To Balance brought forward from 1912 Account				37	12	11
„ Offertories, etc.:						
Chapel	£39	18	4			
Bright Ward	15	3	0			
Box Contributions ...	1	13	5			
				56	14	9
„ Guy's Hospital (Contra): (Grattan's Accounts for Hymn Books)				6	5	0
				£100	12	8

Expenditure.

1913.	£	s.	d.	£	s.	d.
By General Account:						
Floral Decorations, etc.	18	3	0			
Books, Printing, Music, etc.	8	6	7			
Furnishing, Preachers' Fares, and Sundry Expenses	4	12	1			
				31	1	8
„ *Special Offertories:						
Metropolitan Hospital Sunday Fund	1	17	6			
South London Church Fund	8	19	7			
				10	17	1
„ Decoration Account: Panel (Messrs. Jas. Powell & Sons)				50	0	0
„ Balance Carried forward: Cash at Bankers				8	13	11
				£100	12	8

*The Maternity Samaritan Fund Offertory for Christmas, 1913, amounting to £5 6s. 7d., had not been paid over at December 31st, 1913.

Audited and found correct.

(Signed) CHAS. H. WELLS,
Incorporated Accountant.

April 30th, 1914.

Inter-Hospital Billiards.

1st Round.—Guy's beat Charing Cross.

2nd Round (Semi-final).—Guy's beat St. Mary's (holders). Middlesex beat University.

Final.—Guy's v. Middlesex. Played Tuesday, 5th May. Victory for Guy's.

Guy's Hospital Ball, 1913.

Receipts.

	£	s.	d.
To Sale of Tickets	154	7	6
	£154	7	6

Expenditure.

	£	s.	d.
By Princes' Restaurant	103	17	10
„ Joyce's Band	18	18	0
„ Sidney Smith	2	4	0
„ Ash & Co.	4	9	9
„ Gérard	1	5	0
„ Secretarial Expenses	2	10	0
	£133	4	7
„ Profit	21	2	11
	£154	7	6

Receipts.

	£	s.	d.
To Balance from 1912	7	15	9
„ Profit in 1913	21	2	11
	£28	18	8

Expenditure.

	£	s.	d.
By Guy's Hospital Ladies' Association ...	10	0	0
„ Guy's Hospital Maternity Samaritan Fund...	15	0	0
„ Balance at Bankers, held over for next Ball	3	18	8
	£28	18	8

Audited and found correct.

W. J. CURRY,

April 24th, 1914. *Corporate Accountant.*

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S.: Chronic Intestinal Stasis.—*The Practitioner*, March, 1914.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S.: The Operations of Ileocolostomy and of Colectomy.—*Internat. Journ. of Surg.*, April, 1914.

Alfred C. Jordan, M.D.: Intestinal Stasis from the Standpoint of Radiology.—*Ibid.*

Harold Chapple, M.C., F.R.C.S.: The Fundamental Facts of Chronic Intestinal Stasis.—*Ibid.*

F. D. Saner, M.B., B.C.: The Present Status of Intestinal Stasis.—*Ibid.*

D. J. Munro, M.B., B.S.: A Record of Anæsthetics and its Statistical Lesson.—*Lancet*, May 2nd, 1914.

Sir George H. Savage, M.D., F.R.C.P.: Syphilis and Insanity.—*The Practitioner*, May, 1914.

R. A. Chisolm, M.D., B.Ch.: Anæmia in Childhood.—*Ibid.*

Investigation of Native Drugs

From time to time it happens that specimens of plants are sent by Guy's men from various parts of the world, with the idea that they may contain some substance of medicinal importance. In the vast majority of cases the amount of material sent home is far too small to be of any practical use, in other instances, through imperfect drying, the specimen has decomposed on the way.

It may be of some use and prevent disappointment, if a few suggestions are given as to the quantities of material from which practical results may be expected, and the preparation of a specimen for despatch.

1. While suggestive information may often be obtained from quantities as small as 7 lbs., it must be understood that this amount is merely of the nature of a sample, and a thorough investigation can seldom be undertaken on quantities of less than half a hundredweight. These quantities refer to roots, stems, leaves, or bark; in the case of seeds smaller amounts may suffice. The season at which the material is collected is sometimes of great mportance, but cannot be stated definitely beforehand; generally speaking, seeds should be gathered when ripe, and leaves when young and green or when the flower is in bloom, but before the ripening of the fruit, as the active principle is usually at its highest during these periods.

2. It is of the first importance that all substances should be very carefully and thoroughly dried, by preference in the sun, or else at a gentle heat in order to render enzymes inactive. All the precautions usual in harvesting operations should be observed.

3. The plant should be identified in all cases by a competent botanist. When this cannot be done on the spot it is necessary to enclose specimens of flowers, fruit, and leaves, in order that the identification may be carried out here and the relationship of the plant to other known plants determined.

4. Full information with regard to the action or the reputed action of the drug should be included, and it is desirable that the results of personal observation should be given, as it has often been found that native drugs are devoid of activity when tested properly. Plants used for indefinite purposes, such as tonics, rarely give interesting results, but those which are known to have produced symptoms of poisoning will probably prove the most valuable; likewise those plants which develop the odour of oil of almonds (benzaldehyde) when bruised are of great biological interest. It is requested, therefore, that Guy's men, who have access to such material and who wish to have it tested chemically and pharmacologically, should send specimens of not less than seven pounds in the first place; if on investigation the matter seems worth following up, further quantities would be requested, depending on the nature of each case. The materials should be addressed either to the Pharmaceutical or to the Pharmacological Laboratories, Guy's Hospital.

H. FINNEMORE.

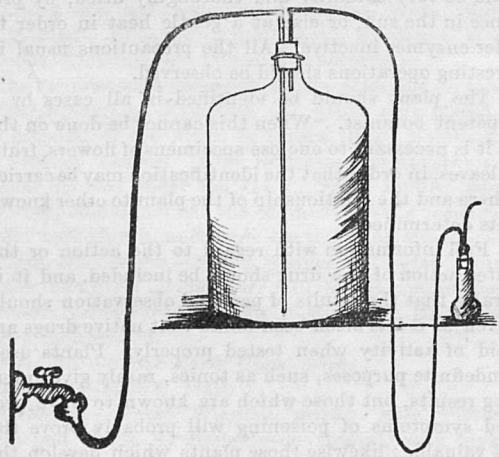
Specialities.

An Efficient Mechanical Spray for Home Use.

By F. H. PARKER, F.R.C.S., Llandrindod Wells.

ANYONE who has used a hand spray for any length of time will agree that it is certainly not an efficient piece of apparatus. It necessitates that while one hand is holding the bottle the other is pinching the bellows, with the result that the head must be bent forward to catch the drops.

The cleansing is likely to be far more complete if the patient sits bolt upright and inhales deeply while the inspired air is saturated with the lotion in the form of a fine vapour. While one hand holds the spray the other should be free to keep a small basin under the chin to catch any drops that fall. Some authorities recommend that a spray should be a decidedly coarse one; the reason for this advice probably is that the amount of fluid introduced by a really fine hand spray is too small to have much cleansing effect. At the same time if all parts of the interior of the nose are to be searched out by a coarse spray there is a danger of infecting cavities which have hitherto remained sterile.



It must obviously be a more perfect method which, in the same period of time, introduces fluid in greater quantities and yet in such a finely divided state that it is practically a vapour. Another objection to the ordinary hand spray is that it seldom lasts long enough; it is a tiring process to keep going for more than a minute at the most. These difficulties can be overcome by various mechanical devices, but it is necessary that the patient should visit some institution and be prepared to pay a daily fee. Probably the patient will not have the money time, or inclination to visit such establishments, and especially if the treatment must be carried out daily for months on end.

The spray which I am about to describe does away to a large extent with the drawbacks of a hand spray, and yet it can be worked quite cheaply in almost every household. The only necessity is that there should be a cold water tap in some convenient position, and close to it a table or shelf strong enough to hold a large bottle.

The bottle, which should hold two gallons, is closed at the top by an india-rubber bung which is pierced by two holes; through these holes pass two glass tubes, one of them connected with the tap and running down to the bottom of the bottle, the other connected with the spray and opening into the top of the bottle. When the tap is turned on quite gently the water rises in the bottle, and air is driven out through the spray.

A two-gallon bottle will work a fine spray for seven minutes; in that time it will vaporize about two and a half ounces of fluid, and will drive the vapour at least a yard. When the bottle is full, turn off the tap, remove the tube from it and let it hang down in the basin beneath; the bottle will empty itself by siphon action. It is necessary, of course, that the basin in which the end of the tube lies should be at a slightly lower level than the shelf on which the bottle stands.

The connection between the bottle and the tap should be effected by an ordinary piece of india-rubber tubing of fairly wide calibre, and if the tap has an ordinary circular bore, a tap union made for a garden hose pipe serves very well for the actual connection; if the end of the tap is not quite round, a wide piece of tubing can be slipped over it. The connection between the bottle and the spray is made by quite a fine piece of rubber tubing. The india-rubber bung must be fastened in securely by string or some other device, otherwise the pressure of air inside the bottle will force it out.

It is absolutely essential that the spray producer itself should be an extremely fine one; nearly all instrument makers sell sprays which are far too coarse for use with this apparatus. A spray producer which has a comparatively large tube can, however, be made to give a fairly fine spray by pinching the end which dips into the fluid until the canal is almost obliterated.

Guy's '89 Club.

THE nineteenth annual meeting and dinner will be held at Hotel Cecil on May 13th, at 7.30 p.m., R. H. Fagge, Esq., in the chair. Will *all* members please return the reply post-cards to the hon. sec. not later than Monday night, 11th inst.?

Appointment.

Arnold Alcock, M.B., B.S. Lond., appointed Assistant Surgeon to the Gloucestershire Royal Infirmary.

The Musical Society.

THE second Choral and Orchestral Concert for the session was held on Friday, May 1st, at 8.15 p.m., in the Physiological Theatre. We have commented in Passim on certain features of the evening and reproduce below, by kind permission of the Editor of the *Daily Telegraph*, the criticism of the music which appeared in that paper.

MUSIC AT GUY'S HOSPITAL.

An interesting and delightful programme of music was that performed in the Physiological Theatre of Guy's Hospital last night at a choral and orchestral concert given by members of the musical society. This society, a well-established institution, prospers exceedingly, under the careful and able direction of Mr. W. Denis Browne, and there was a large audience present of nurses in uniform, students, and members of the hospital staff. Bach's D minor Concerto for two violins and orchestra (in which the solo instruments were played by Nurse E. A. Smith and Nurse Hayne) headed the programme, which contained, among other things, Parry's "Blest Pair of Sirens" and Vaughan William's "Five Mystical Songs" and "Three English Folksongs," the last being performed in London for the first time. The three folksongs are "The Dark-eyed Sailor," "Just as the Tide was Flowing," and "Wassail Song," beautiful things each, and arranged in a free and splendid way for unaccompanied chorus. With the limited resources at his disposal the conductor achieved quite admirable performances of the various compositions. The solo vocalists were Mr. H. Thompson, Mr. Clive Carey, and Mr. J. Stuart Wilson.

Daily Telegraph, May 2nd, 1914.

Reviews, etc.

Mechanism, Life, and Personality. By J. S. Haldane, M.D., LL.D., F.R.S. (London: John Murray.) Price 2s. 6d. net.

In the course of 140 pages Dr. Haldane reviews the whole of the philosophical basis of physiology. This book should be of special interest to Guy's men since it consists of the four lectures delivered by the author in the Physiological Laboratory, Guy's Hospital, in May of last year.

The book is divided into four sections, each section consisting of one lecture reproduced almost in its original form.

The first lecture gives an exposition of the mechanistic theory of life and is studiously fair. It ends, however, with a very perfunctory criticism of the Vitalistic Theory.

The second lecture is devoted to a criticism of the Mechanistic Theory. After an admirable historical account of the Mechanistic Movement, the author proceeds to develop his case against it. So far as we can follow him, we gather that while the theory has explained much, in some directions it has failed. Then comes a whole-hearted damnation of the entire position. Doubtless the steps were lucid to Dr. Haldane, but in this lecture they seem to lack sequence.

Investigation into the problems of reproduction is banned as unholy: Professor Loeb and his "fatherless frog" are seen swimming desperately in a flood of ridicule.

The author assures us that he would as soon go back to the Mythology of his Saxon ancestors as to mechanistic physiology.

Lecture III. is termed "Biology and the Physical Sciences." It is the best of the series, and should be read by everyone engaged in scientific research.

It traces the philosophical conception of reality from the time of Berkely and Hume to the present day. It is a triumph of lucidity, and makes reading which may even be termed dramatic.

At the end Dr. Haldane seeks to apply these conceptions to the controversy between Vitalists and Mechanists, and his lucidity becomes clouded.

The final lecture deals with "Consciousness." We are assured that conscious activity cannot be dealt with scientifically from the merely physiological standpoint; and that "Physiological psychology is nothing but a misbirth of modern times, inevitably doomed to perish."

We cannot but find this surprising in the face of Pawlow's work on conditional reflexes, which seems to come as a beam of light through the fuddling mists of orthodox psychology.

Lastly, we have an exposition of what we take to be the author's own position—a form of Pan-vitalism, curiously similar to the genteel mysticism of Rabindranath Tagore.

Diseases of the Heart. By John Cowan. (London: Edward Arnold.) Price 15s. net.

There will be many to whom this book should prove extremely welcome and opportune—both medical men, to whom the new terminology and the modern revolutionary conceptions of cardiac pathology are upsetting and bewildering, and students, who find that the ordinary textbook descriptions are out of date and inadequate. While everything is retained that is valuable in the older work, founded on the results of clinical observation and post-mortem examinations, the book is saturated with the new spirit and the new methods of instrumental examination; and the value of the whole is very considerably enhanced by the inclusion of copious and admirable illustrations and reproductions of charts. The great difficulty with the polygraph and the electro-cardiograph, besides the difficulty of the technique, is the difficulty of interpretation. The principles underlying these interpretations are laid down here in clear, concise language on plain, commonsense lines; the chapter on the electrocardiogram is especially excellent. We can cordially recommend the book to all who would get a clear picture of the present-day attitude towards the various aspects of cardiac disease.

Therapeutics of the Circulation. By Sir Lauder Brunton. (John Murray.) 5s. net.

This is a very full and instructive treatise on the subject of cardiac therapeutics. It has the merit of being at the same time eminently scientific and practical, and although much space is devoted to physiological considerations and cardiographic work, the aim embodied in the title is in no wise neglected. It is, in point of fact, becoming more and more necessary to base the treatment of cardiac disease on the findings of the scientific as well as on those of the clinical observer. In spite of the small compass of this volume, every aspect of cardiac physiology, pathology, and pharmacology is adequately presented, and full references to the literature are included throughout. It should certainly give pause to all with too empirical tendencies, by demonstrating the complexities and minutiæ of the subject, and reminding them of the numerous lines of treatment available, apart from the broad routine of "bed and digitalis."

Outlines of Greek and Roman Medicine. Elliott. (Bale & Danielsson.) 7s. 6d.

Until recent years the History of Medicine has been badly neglected. Any publications dealing with the subject are therefore welcome. This little volume is devoted to the Greek and Roman periods, and as a summary is quite presentable. In so short a space the author could scarcely hope to do more than sketch the salient features of his subject. His sketch has the merits of being both interesting and instructive, and should at any rate spur the reader to extend his researches in a romantic realm.

The chief impression to be gathered in a perusal of medical history is that of the extreme antiquity of many devices supposed to be essentially modern. Even the magnitude of surgeons' fees appears to find justification in distant precedent.

Modern Anæsthetics. By J. F. W. Silk, M.D.

This small book contains the views of Dr. Silk as the result of his own practical experience; it is written in an easy style, and many useful points are introduced. Guy's men, who see "open ether" used so successfully and constantly at the hospital, may be surprised to find only a few lines devoted to a description of this method. Dr. Silk says that ether "is not so easy to give" as chloroform in abdominal cases; we do not agree with him here. In referring to the use of preliminary alkaloids, no mention is made of, perhaps, their most valuable property, that of diminishing the secretion of mucus when ether is used.

In speaking of posture, the author says that chloroform should never be given to a patient in the sitting position; many anæsthetists, however, always administer it in this way for certain throat cases with apparently no bad results. He also considers it a dangerous position in which to administer ethyl chloride and thinks that this drug should not be used for dental cases; at Guy's it is constantly given to children in the dental department with no bad results and with a far more satisfactory anæsthesia than can be obtained from nitrous oxide. The book is thoroughly up to date, containing descriptions of intra-tracheal ether, the rectal administration of a mixture of ether and olive oil and Crile's theory of "shock" and his method of securing "anoci-association."

Dr. Silk is never dogmatic; he treats the views of other anæsthetists with respect, though they may not happen to be in accordance with his own.

The Principles and Practice of Medical Hydrology. By R. Fortescue Fox, M.D. (London Medical Publications.)

This book should be of value to the medical practitioner, as providing within a modest compass of some 300 pages, a very complete account of balneology and hydrotherapy. It is essentially from the practical point of view that we would recommend it, as a book that describes in detail different forms of treatment, and the appropriate indications in disease. Such a book should be of value in this country where the subject of bathing hardly comes into the curriculum of medical education.

Although treatment of this kind is as old as mankind, it still remains in the empirical stage. The Spa-physician has rarely tried to get to the bottom of his subject, and is guided for the most part by his own unaided experience, and so-called intuition.

It is true that the physiological effects of baths of all kinds on healthy men have been discovered, but these results provide no explanation for the effects in disease. We are as far away from a rational explanation as ever, and this is but natural, seeing that we are ignorant for the most part of the causes of the diseases themselves.

The chief fault of the book is in the so-called explanations of the value of any particular treatment; explanations which sometimes lack precise meaning, and at other times are suggestions with no evidence for or against; but this is a fault too often present in medical publications. Suffice it to say that hydrotherapy has been found useful in a large number of chronic intractable diseases. Let us hope for some rational explanations in the future.

Births.

SAUL.—On April 30th, at Pretoria, Transvaal, to Alec. L. Saul, M.R.C.S., L.D.S., and Mrs. Saul, a daughter.

PINCHING.—On April 26th, at Frampton-on-Severn, Stonehouse, Glos., the wife of W. G. Pinching, M.R.C.S., L.R.C.P., of a daughter.

MUNDEN.—On April 24th, at Ilminster, Somerset, to Dr. and Mrs. Henley Munden, a daughter.

Death.

BARKER.—On April 6th, at Lahore, India, Keith Auriol Barker, the only son of Captain and Mrs. F. A. Barker, I.M.S., aged 1 year and 10 months (Acute Dysentery).

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 676.] MAY 23, 1914. [SIXPENCE.

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Passim.

THE report on Spiritual Healing, which has recently been issued by "a clerical and medical committee of inquiry into spiritual faith and mental healing," will repay perusal. In more ways than one it is an encouraging report. Firstly, as evidence of a *rapprochement* between the representatives of science and religion and of a general increase in intellectual latitude, it must appeal to all progressively-minded people. Secondly, by serving to clear the ground in a matter involving disputes of some perplexity, it must be considered, from everybody's point of view, a valuable publication. To the medical profession it should prove gratifying in so far as it emphatically recognises the great importance of medical opinions in all cases of disease, and deprecates "the independent treatment of disease by irresponsible and unqualified persons." To the clerics it should also give satisfaction in that it contains the testimony of medical men of eminence to the actual and potential value of their work, and offers at the same time scientific support for curative, spiritual phenomena. But above all it is deserving of recognition by the laity, for to them it is at once explanation, advice, and warning, and evidence of the high-minded interest and sympathy bestowed on them by the two great professions which are endeavouring to make the welfare of humanity their foremost concern.

WE quote below, for purposes of comment, some interesting passages from the conclusions of this Committee—a Committee representative of the best brains of the clerical and medical worlds:—

"The Committee are of opinion that the physical results of what is called 'Faith' or 'Spiritual' healing, do not prove on investigation to be different from those of mental healing or healing by 'suggestion.' The term suggestion is used in this report in a wide sense, as meaning the application of any natural mental process to the purposes of treatment.

"The Committee believe that while the reinforcement of the faith, hope, courage, and strength of the sick by religious influences does not essentially differ in process of operation from that derived from non-religious appeals to the mind, yet that the former may often be the most potent form of suggestion.

"They are aware that no sharply defined fundamental distinction can be drawn between 'organic' and 'functional' ailments. They are forced, however, to the conclusion, after the most careful inquiry, that 'Faith' or 'Spiritual' healing, like all treatment by suggestion, can be expected to be permanently effective only in cases of what are generally termed 'functional' disorders. The alleged exceptions are so disputable that they cannot be taken into account.

"The Committee would emphasise this point in order to warn those who resort to

'Healers' in the hope of receiving a permanent cure that they may thereby be postponing until too late the medical treatment which might serve to arrest organic disease."

WE find these conclusions eminently sane and reasonable, and sincerely hope that they may become sufficiently widely circulated to assist in diminishing the small (but growing) toll of human lives which are annually lost through perversions of belief. The most apparent conclusion to be drawn from these pronouncements would seem to be that belief in the natural, as apart from, though not necessarily at the expense of, the supernatural, is finding a firmer stronghold in men's minds, and even in the minds of those with strong religious inclinations. It would be interesting to speculate as to the goal to which this tendency will ultimately lead, but such speculations are beyond the scope and sphere of Passim.

THE lack of correlation between the various scientific departments of the Hospital, and between the several departments and the wards, must constitute a very conspicuous shortcoming in the eyes of such persons as worship at the shrines of Organization and Efficiency. While everyone suffers from this lack of correlation, it would seem that those employed in research of one kind and another are especially liable to be handicapped, and consequently it is to these that we would particularly turn our attention, and from the ranks of these that we shall particularly expect reformers to arise. At present an enormous amount of material must be wasted merely through lack of knowledge of its existence on the one hand, and lack of knowledge that it is required on the other. We would suggest, as a tentative beginning, that all those engaged on research should combine and issue periodically some announcement of the researches in which they are interested, and of the materials, clinical, bacteriological, or pathological which might prove of value to them. In this way it should become possible for house-officers and others to render assistance to the laboratories and perhaps occasionally to benefit themselves in consequence.

IT should not be necessary for a man interested in a particular disease to prowl round the wards until he can find a case, or for a man interested in a particular pathology to wait in the post-mortem room in the hopes that he may save a specimen from consignment to the Museum or destruction. All that is necessary is the occasional publication of a list of requirements. It might even be possible to set aside a column of the GAZETTE for so excellent a purpose.

WHILE dealing with topics relating to organization and efficiency, we would call the attention of our readers to an address of which the first part appears in this issue, on "The Need for Organization in the Nursing Profession." The Address was given at a recent nursing conference in London, by Miss Margaret Atkey, Matron to the Royal Gwent Hospital, and a former sister of Guy's Hospital. It is an excellent paper and admirably timed. We are all finding it necessary nowadays to reconsider our relations to the life of the community. As individuals, and as groups of individuals, we have a great deal of remodelling to do, and with questions such as State Registration on the near horizon, it would seem that the nursing profession is confronted with as many activities and difficulties as have of late been falling to the lot of the medical profession.

WE omitted to mention in our last issue, among the other recent innovations, the opening of the Salvarsan Ward, containing three female beds. With the value of salvarsan becoming daily more assured, and the importance of thorough treatment (in view of recent discussions and the findings of the Royal Commission on Venereal Diseases) more than ever manifest, it is high time that the Hospitals should be well supplied with accommodation of this kind. Here, too, is an added opportunity for research, bacteriological, and pharmacological. A letter by Professor Erhlich in a recent issue of the *British Medical Journal*, written in response to an article which referred to a case in Clinical, apart from its other interests, is instructive as a reminder of how much we have yet to learn of the action of this remarkable drug.

The Rev. A. E. Popham recently left the Hospital after a long period of strenuous and devoted work on its behalf. During his Chaplaincy he won for himself a widespread popularity and esteem among all sections of the community. Staff, students, nurses and patients alike found a valuable friend in him, and the energy and interest he displayed over every branch of his work won for him a reputation which is not likely to lapse. He has made a special study of the case of the attempted suicide, and intends, we believe, to continue to interest himself in this much-needed work. We feel sure that we are voicing a general opinion in uttering our good wishes for his career in other spheres, and in expressing our hope and belief that he may not be entirely lost to Guy's.

We omitted to record in our last issue the resignation from the Dental staff of Mr. H. P. Aubrey. Mr. Aubrey entered the Hospital in October, 1900, qualified L.D.S. in May, 1903, and took the Conjoint Diploma in 1907. He was elected Travelling Scholar in 1905 and proceeded to Harvard University. After holding junior staff appointments in the Dental School he was elected Assistant Dental Surgeon.

Mr. H. C. Malleson, who also held the Travelling Scholarship, has been elected to fill the vacancy caused by Mr. Aubrey's retirement.

The Hospital Athletic Sports will be held at Honor Oak Park on Saturday, June 6th, when Mrs. Hertz has kindly consented to distribute the prizes. It is to be hoped that there will be a big entry and that the junior men especially will endeavour to supply a number of prospective Olympic Champions. A large attendance is anticipated.

Appointments.

R. Affleck Greeves, M.B., B.S., F.R.C.S., has been appointed Assistant Ophthalmic Surgeon to the Middlesex Hospital.

W. S. Kidd, M.B., B.S., has been appointed Medical Officer to the Yorkshire Home for Incurables, Harrogate.

The Biennial Dinner, 1914.

Dear Mr. Editor,

As already announced in the Gazette, it is "Biennial" year once more, and before this letter appears in print I hope that all Guy's men will have received their invitations to the Dinner on Friday, 3rd July, at the Connaught Rooms, Great Queen Street, and that a large number will have already made up their minds to accept.

Over 2,000 invitations have been issued, and every care has been taken to ensure that everybody shall receive one, but if anyone reading this letter has by some mischance not already had a notice, he will find an announcement of the Dinner and a form upon which he can apply for a ticket amongst the advertisements at the end of this number of the Gazette.

Again, any who are about to return from abroad in time for the Dinner, or who know of others likely to do so, will, I trust, communicate with me, as the Committee desire particularly to secure the presence of those to whom the chance of attending the Dinner is less frequent than biennial. That they will enjoy themselves if they do come goes without saying.

There are to be no speeches, only three toasts, as in 1912, so that men will have plenty of time to seek out and talk to their old friends, and the fine hall at the Connaught Rooms, in which the Dinner is to be held, affords ample space for getting about easily from one point to another.

In accordance with previous custom, notices have not been sent to present students, but I need not say that all who can come will be welcome. Copies of the invitation may be obtained by students from the Librarian.

I hope to publish *in the* Gazette *of June 6th* the first list of those who have decided to come to the Dinner, and I much hope that it will be a long list, for it is not only exceedingly helpful to me to hear of those who are coming, as soon as possible, but it encourages others, who may be in two minds about it, to accept when they see that their friends have already decided to come.

If any vice-chairman would find it useful to have a list of his contemporary dressers or residents, I will send it to him with pleasure on receiving a post-card to that effect.

I am, Sir,
Yours sincerely,
F. J. STEWARD,
Hon. Sec.

98, Portland Place,
W.

Intratracheal Insufflation of Ether.

BY FRANCIS E. SHIPWAY.

OF all the recent methods of general anæsthesia none has aroused so much interest as the discovery by Meltzer and Auer of intratracheal insufflation. It may be said to be the most valuable of them all, for it is not only a method of anæsthesia, but is primarily and essentially a method of artificial respiration. It is thus a unique combination, and its use is not confined to surgery alone.

The original communication of Meltzer and Auer and their later papers well repay reading. References to these and to the earlier ones in this field, including the experiments of Robert Hook in 1667, are given in an article published by me in the *British Journal of Surgery*, July, 1913, page 101, and a fuller description of the method appeared in the *British Medical Journal*, December 27th, 1913, page 1621. I feel that I owe no apology for again referring to this subject, because, although the method is simple and safe, it is not fool-proof, and it is only by a complete knowledge of the principles and the technique that certain dangerous mistakes may be avoided. Neglect of simple precautions has already led to disastrous results.

In intratracheal insufflation a continuous stream of warmed and moistened air is introduced at the bifurcation of the trachea by means of a catheter which has been passed down the mouth and through the larynx. The catheter is of such a size that it fills about one-half, but not more, of the glottis. The air is under pressure and returns upwards between the catheter and the walls of the trachea to escape from the mouth and nose. The volume of air is ample to distend slightly the lungs and to fulfil the function of respiration in the absence of respiratory movements. With intratracheal insufflation of air an animal under curare with the thorax widely open can be kept alive for hours. What is the explanation? Normal respiration is an exchange of gases between the tidal and alveolar air by diffusion. The movements of respiration only change the air in the trachea and larger bronchi. If the air-cells opened on the surface of the body and were thus in immediate communication with the external air, no respiratory movements would be necessary. By cutting out, therefore, the greatest part of the dead space, that is, the space between the atmospheric air and the alveoli, and by supplying under pressure a continuous stream of pure air, a powerful and increased diffusion of gases within the bronchi results and ventilation is complete. Regular reductions of the air-stream are made several times a minute for a second or two to help the exchange of the gases by allowing the lungs to contract and expand; they are also of service in releasing the continued pressure on the great vessels of the thorax.

The importance of pushing the catheter down to the bifurcation is shown by the observation that the further away from this situation the catheter is placed the shorter is the life of a curarized animal.

Animals which have been given intravenously twice the fatal dose of strychnine, or in which ether administration has been pushed until the heart has stopped beating for several minutes can be easily resuscitated. Elsberg was the first to use the method in the human being, in a case of myasthenia gravis where respiration was failing from muscular paralysis, and he related at the International Congress of Medicine last summer a case of attempted suicide by morphia in which insufflation was kept up for twelve hours, during the whole of which time there were no movements of respiration. The patient, a medical man, recovered. Peck resuscitated a man apparently moribund from dyspnœa caused by a large thoracic aneurysm. I have been able on two occasions on which respiration stopped from causes unconnected with the insufflation to restore it to its proper vigour in a short space of time.*

Meltzer found that by passing the air-stream through or over ether anæsthesia could be easily maintained. Intra-thoracic surgery becomes practicable in the absence of a complicated and expensive pressure cabinet or chamber. Insufflation is safer, because, as we have seen, it does not depend for the maintenance of life upon the efficiency of the respiratory movements, already crippled by the operation. Many remarkable intra-thoracic operations have been done in the laboratory by Meltzer, Carrel, and others. The first successful case of removal of a growth of the œsophagus through the thorax has been accomplished under this form of anæthesia.

Intratracheal insufflation of ether has considerable educational value, for it shows the true lines upon which anæsthesia should be conducted. What these are, and the additional advantages offered to the surgeon and to the anæsthetist, must be briefly described.

1. Administration is automatic and even. The dosage can be accurately regulated and anæsthesia is under absolute control, the reason being that any desired ether percentage can be given with precision and maintained with unvarying regularity. Once the requisite depth of anæsthesia has been discovered very little anæsthetic is needed to keep this constant. Intake and output can be nicely balanced. Cotton and Boothby have kept a cat alive for 16 hours under nitrous oxide and oxygen with the pleural cavities widely open. The cat was left in the laboratory all night without observation and recovered within fifteen minutes of the withdrawal of the anæsthetic. This experiment shows in a striking manner the advantages and possibilities of a definite and constant ad-

*Proc. Roy. Soc. Med., Anæsthetics, vol. vii., No. 5, page 32.

ministration. The method also is flexible: anæsthesia can be rapidly deepened or diminished.

2. The air-way is unobstructed. In inhalation anæsthesia the chief difficulty, and the source from which dangers mainly arise, is the occurrence of some form of obstruction in the upper air passages due to congestion or spasm produced by the irritation of the anæsthetic vapour, or to mechanical blocking caused by paralysis, *e.g.*, of the tongue and lower jaw. Excessive mucus formation impedes still further the free entry of air. Much of this difficulty is eliminated by the use of some form of artificial "air-way." It is not, however, completely abolished, and its continued presence adds to the shock of operation or actually produces shock by the effect of cyanosis upon an over-burdened heart. Now, if we introduce the anæsthetic directly into the blood as intravenously, or below the larynx, *e.g.*, through a tracheotomy tube, or per rectum, we avoid almost entirely this difficulty, and find that anæsthesia is quiet and smooth and uncomplicated by cyanosis. The same reasoning applies particularly to intratracheal insufflation. Aëration is constant and sufficient, the patient is certain of receiving under all conditions an ample supply of air.

3. As a result, then, of these two factors, viz., even administration of the maximum amount of anæsthetic and an unobstructed air-supply, shock is considerably diminished. Dr. Marshall says there is no marked fall of blood pressure even during a long operation.* Clinical observation had previously pointed to this, and I was glad to have his corroboration.

4. A point of much practical interest and value was early established by Meltzer, viz., that the return current of air issuing from the end of the catheter creates a strong upward draught at the glottis which effectually prevents the aspiration of any blood, mucus, or infective material. I have also pointed out that so much of the respiratory movement as is present is almost entirely expiration, inspiration being reduced to a minimum. The method is, therefore, invaluable in the surgery of the mouth and pharynx, and has met with the universal approval of those who have used it. The surgeon has a clear field without being harassed by the close presence of the anæsthetist, the mouth may be full of blood without any getting down into the larynx, and the breathing is always regular and unobstructed, so that the comfort and freedom from anxiety of all concerned are remarkable, and emphasize the advantages of the method. Patients make a quick recovery; vomiting is rare, largely because nothing can run down into the stomach, and aspiration pneumonia is entirely eliminated. I have used this method in 75 cases of this description, chiefly for operation, in some for examination of the deeper parts of the pharynx, and in others for œsophagoscopy. Some of the operation cases have been very interesting from the anæsthetist's point of view, and would have necessitated a preliminary laryngotomy had not this method been available.

5. The field of operation for the surgery of head, face, or neck is not encroached upon by the anæsthetist, and can be kept sterile.

6. The quiet type of breathing and the slight character of the respiratory movements facilitates the surgery of the upper abdomen.

The type of anæsthesia is excellent and quite unlike that seen in any other method. The patient appears to be in a calm sleep with a rosy-pink colour, firm, regular pulse, brisk reflexes, relaxed muscles, and quiet very light respiration. In fact, at first sight respiration appears to be completely suspended, but on listening carefully a constant stream of air is heard issuing from the mouth with which are mingled faint inspirations and stronger, but weak, expirations. The lightness of anæsthesia is interesting. I have several times noticed patients open their eyes and go to sleep again without apparently showing any annoyance with the surgeon. Esberg makes the same observation. This phenomenon is explained by realising that in inhalation anæsthesia the administration of constantly varying percentages of ether vapour brings into play inconvenient reflexes which can only be subdued by unnecessarily deep anæsthesia.

At the end of the administration pure air is substituted and the ether blown out of the lungs, recovery rapidly ensuing, so that patients are often fully conscious on leaving the table. The knowledge that at any moment during a critical case artificial respiration is at hand by merely turning a tap is of considerable help to the anæsthetist.

Indication for its use.—a. Since it is primarily a method of artificial respiration, it follows that it can be used to great advantage in any case in which respiration is, or is likely to be, interfered with, viz., by mechanical obstruction (*e.g.*, goitre or other neck operations), by position of the patient (*e.g.*, renal and spinal operations), by diseases connected with the central nervous system (*e.g.*, cerebellar tumour), by habits or physique of the patient (*e.g.*, heavy smokers, alcoholics, stout, thick-necked individuals, etc.).

b. In operations on the thorax when the pleura may be opened of purpose or by accident.

c. In operations on the nose, mouth, pharynx, or for intestinal obstruction with vomiting.

d. In debilitated, exhausted, or cachetic patients.

e. In operations on the upper abdomen.

Dangers and Precautions.—It must not be forgotten that the air-stream is under pressure, and *provision must be made for its free exit.* A safety-valve is absolutely essential to prevent any sudden or prolonged dangerous increase in the intra-thoracic pressure. Usually a limit of 20—25 mm. Hg. is safe in the adult; any excess causes the valve to "blow off." The actual pressure in the trachea and in the bronchi is only a

*Proc. Roy. Soc. Med., Anæsthetics, vol. vii., No. 5, page 36.

small proportion of the pressure in the manometer. The smaller the catheter the lower is the actual intra-tracheal pressure. *The catheter must not occupy more than one-half of the glottis*, to prevent cyanosis and restricted elimination of carbon dioxide.

In feeble and emphysematous patients high pressures and rapid ventilation must not be used; similarly a disabled lung must be treated with caution. Danger may arise from *excessive pressure on the trachea, e.g.*, during thyroidectomy, or during operation on the lower jaw or larynx, or from flexion of the neck in certain operations. The surgeon must be warned of this, or the air-stream momentarily cut down. This danger is not likely to arise if a safety-valve is provided, but the anæsthetist must not forget the possibility of its occurrence.

The catheter must not be pushed down too roughly nor too far into the trachea. For this reason catheters should be marked at a distance of 23 c.m. and 26 c.m. from the tip, these figures representing the average distance in women and men respectively from the incisor teeth to the bifurcation. In children (aged 10) it is about 17 c.m.

Interruptions in the air-stream at regular intervals are, as stated above, of importance.

The respiratory movements should not be abolished. A state of apnœa may be maintained in which circulation and blood pressure remain for some time satisfactory; but blood pressure is steadily falling. Cessation of breathing, then, is not desirable, for it is a sign that the respiratory centre in the medulla is overdosed by ether and that the vaso-motor centre will shortly be affected. *Too* rapid a ventilation will remove carbon dioxide too quickly from the blood. Dr. Pembrey* has made many observations on some of my cases with reference to this point, and has shown that with a ventilation of about 16 litres per minute the pressure of carbon dioxide is between 5 and 6 per cent. of an atmosphere, and the respiratory movements are definite.

Space does not allow a description of technique nor a discussion of complications, both of which have received full attention in the papers previously quoted. I can only say here that complications are few and slight. Vomiting and nausea are markedly diminished. Laryngitis has occurred once in nearly 300 cases. Some patients, usually women, have had some temporary discomfort, noticed chiefly on swallowing Bronchitis is very infrequent and has been practically limited, as would be expected, to upper abdominal cases. I have not hesitated to use this method on patients of ages ranging between 7 and 78 years, some of whom already had chronic bronchitis. The ages of the mouth and throat cases have been naturally high, and the results have been uniformly good. A warm, weak, ether vapour is not harmful in these, nor in any case; it is only when massive doses have been necessary in an abdominal operation that there is, as with other methods of etherization, the possibility of an acute bronchitis being started.

My experience is that this method has much widened the limits of ether, and is undoubtedly the safest and best method of administering this anæsthetic. I think it is the ideal method in the surgery of the neck, especially in thyroid cases with obstruction, and in the surgery of the mouth and pharynx. I do not go so far at present as to say that it should be used as a routine, although it is so used in some hospitals with complete satisfaction and with better results than with any other method. Its wider adoption will always be hindered by the difficulty of passing the catheter. This is a serious misfortune, for, apart from surgery, the method has its value in medicine, and circumstances may arise any day in which its use might be the means of prolonging or saving life.

*Proc. Roy. Soc. Med., Anæsthetics, vol. vii., No. 5. page 35.

Notices.

For the Welfare of Infancy.

THE Right Hon. Herbert Samuel, President of the Local Government Board, will give the Inaugural Address at the National Conference on Infant Mortality, which is to be held at Liverpool on July 2nd and 3rd. Many important subjects are down for discussion, including milk sterilisation, ante-natal hygiene, the teaching of infant hygiene to the elder girls in elementary schools, the scope and functions of schools for mothers and the special responsibilities of sanitary authorities in regard to infant welfare. A large number of local authorities and voluntary associations for infant welfare have already appointed delegates.

Change of Address.

R. Davies-Colley, M.C., F.R.C.S., from 24, St. Thomas's Street, S.E., and 30, Weymouth Street, W., to 10, Devonshire Place, W. (Telephone, Mayfair 6749.)

Dr. W. J. Rowland, from 5, College Road, Brighton, to Roseg, Whitstable, Kent.

Surgeon G. B. Cockrem, R.N., from Royal Naval Barracks, Portsmouth, to H.M.S. *Black Prince*, Mediterranean.

F. William Cock, M.D., from 1, Porchester Houses, Porchester Square, W., to 19, Randolph Road, Maida Hill, W. (Telephone, Paddington 1128.)

Dr. E. P. Poulton, from 21, Belmont Park, Blackheath, S.E., to 24, St. Thomas's Street, London Bridge, S.E. (Telephone, Hop 2135.)

F. Tooth, from Royal Infirmary, Gloucester, to The Old House, Nether Stowey, Bridgwater.

Lieut. G. C. Covell, I.M.S., from Army Medical College, Millbank, to McGrigor Barracks, Aldershot.

Some Causes of Obstruction of the Ureter.

CLINICAL LECTURE BY Mr. R. P. ROWLANDS.

Gentlemen,—I have chosen this subject for my lecture because I happen to have two interesting cases of this kind in the hospital at the present time.

Case 1.—The first patient is a woman, æt. about 30, sent by Dr. Hollings some two years ago for pain in the right flank. This came in attacks unassociated with fever. The pain was worse in front, but often ran up towards the right loin. I found a tender area over the ascending colon in front, and I diagnosed a retro-cæcal appendix with appendicular colic, but I sent her to be radiographed, and to my surprise Mr. Shenton saw a stone just above the crest of the ileum, which he thought might be in the lower pole of the kidney or in the upper part of the ureter. On admission into the hospital the patient was examined again with the X-rays twice, but no stone showed. Therefore I reverted to my original diagnosis of retro-cæcal appendix. I removed this in the usual way. It was chronically inflamed and it was lying behind the cæcum, but I was not quite satisfied that it was the cause of the colic, as there did not seem to be any obstruction of it. I felt the kidney through the peritoneum, and it seemed to be normal. After some months the attacks of colic returned. They were never associated with hæmaturia or swelling. The patient was examined with the X-rays again, and again a stone was seen. I therefore explored the right loin and found the pelvis moderately dilated due to an abnormal renal artery, which passed behind the junction of the ureter and pelvis and constricted the channel; when the kidney descended a considerable pouch of the pelvis came down behind the abnormal artery. On dividing the artery a marked constriction was still present at the junction of the ureter and pelvis, and the opening of the ureter was about two inches above the lower pole of the pelvis. Therefore I enlarged the opening after Finney's method of gastro-duodenostomy, and through the opening thus made I examined the kidney but without finding any stone, except a collection of grit in an abscess the size of a filbert at the lower pole of the kidney, connected with the lower calyx. I scraped this away and drained the kidney. As the kidney was too movable I performed nephropexy. The patient made a slow but good recovery, but about a year later she began to have attacks of colic again, and I had her X-rayed several times with a negative result, and I thought a stricture of the ureter had probably formed again. About a month ago she was radiographed again and a stone was shown just above the crest of the ileum. She was re-admitted and I explored the kidney and found it intimately adherent to the right flank in a good position. It was difficult to get at the pelvis from behind. Therefore I peeled the peritoneum off the front of the pelvis, which was still somewhat dilated, and made a vertical incision on its anterior surface and passed a catheter down into the bladder without any difficulty. The finger inside the pelvis discovered the small opening of the upper calyx, and on stretching this and passing the finger up a round stone, the size of a small filbert, was felt. I was unable to deliver it through the pelvis, and therefore cut directly upon it through the cortex of the kidney, removed it, and then sewed up the opening in the pelvis. I am glad to say that the patient is now doing well. I think the sequence of events in this case is an abnormal renal artery kinking the ureter when the movable kidney descended, and the stone was secondary to the obstruction. It is more than likely that the stone which I removed at the last operation, was there at the orignal one, and probably at the moment lying above the very narrow neck of the upper calyx.

Case 2.—A man, æt. about 45, from Dr. Lacey, has had repeated attacks of colic in the left side for the last eighteen months. I first saw him about a year ago, and he was skiagraphed with a negative result. The urine was normal on repeated examinations. The lower pole of the left kidney could be felt. A belt was tried without any relief. The attacks became more and more frequent, and at one time laid the patient up for three months. It interfered very much with his work. As soon as he got work he had to give it up on account of the pain. He at last begged for an operation. He never had any hæmaturia, and the pain was typical of renal colic and sometimes very severe, but he never had any retraction of the testicle or noticed any variation in the amount of urine passed. He was examined with the X-rays again with a negative result. The kidney was explored and a dilated pelvis was seen. An abnormal renal vessel was also seen, and a condition generally very similar to the one already described in the first case was found, and similar treatment was adopted, but no stone was found. The

patient had a good deal of pain along the course of the ureter for a few days, with some extravasation of the urine in the retro-peritoneal tissues, but he is now making a good recovery.

Three other similar cases have been under my care in the last four years, in one of these the ureter was strictured opposite the constricting vessel, probably owing to secondary inflammatory changes, the result of long continued pressure. In the third, a lady under the care of Dr. Halstead, there was no stricture, and when the abnormal vessel was divided a pint of urine was squeezed into the bladder. No plastic operation was necessary, and the ureter was not opened. The patient was well about two years later.

Having shown my two patients I shall draw your attention to some of the most important causes of obstruction of the ureter. No exhaustive list is attempted.

a. Foreign bodies inside the ureter.—Stone or gravel; blood clot as from injury, growth or tuberculous disease of the kidney; tuberculous debris blocking the narrow channel of a tuberculous ureter; small hydatid cysts passing down the ureter.

b. Changes in ureteral wall.—Stricture, congenital or acquired; valve formation at junction of pelvis and ureter; myoma or other growths of the ureter.

c. Pressure upon the ureter by—Abnormal blood vessels, especially when the kidney is unduly movable; growth, especially of the uterus (the pregnant uterus); and abscess. I have known an abscess in the lower end of the kidney completely obstruct the only ureter.

Symptoms.—Sudden obstruction of the ureter causes a characteristic, spasmodic and severe pain which runs from the loin downwards and inwards into the groin and often into the testicle, which may be retracted. In some cases the pain runs down the thigh. In others the pain does not go down into the groin but is a semi-girdle pain about the level of the umbilicus. As a rule the pain is intolerable, the patient cannot sleep or lie still, nausea or vomiting are associated with it, and there may be faintness, pallor or even shivering. Generally there is some abnormality of micturition, mostly frequency, irritability and, perhaps, strangury. Usually there is deep tenderness in the loin and sometimes a swelling can be felt descending below the costal margin on deep respiration.

Diagnosis.—A. *Renal colic has to be distinguished from other severe pains in this region,* especially appendicular, biliary, intestinal, and pancreatic colic. Appendicular colic is rarely so severe as renal colic, and is not often associated with urinary symptoms except when the appendix is low down in the pelvis or is lying close to the ureter. As a rule there is tenderness over the appendix and more intestinal symptoms such as chronic indigestion and, perhaps, a slight elevation of temperature, which is rare with renal colic. Intestinal colic due to lead, is characterised by the lead line and constipation, and is mostly located about the umbilicus. Biliary colic is higher and chiefly located in the right hypochondriac and epigastric regions. The pain in the back is higher and it rarely ever runs down into the groin, except when the gall-bladder is unusually low. It is a common mistake to expect jaundice with biliary colic; really it is exceptional, for a stone more commonly obstructs the cystic than the common bile duct. The renal crisis of locomotor ataxy are always to be remembered. Fortunately they are not very common. Intercostal neuralgia due to growth or spinal caries or aneurysm is also to be remembered, and an X-ray examination is often valuable in distinguishing these. These pains are rarely unilateral. The preliminary pains of herpes Zoster have been mistaken for renal colic.

B. *The various causes of renal colic have to be distinguished from each other.* Of all these, stone gives the most severe pain and is most frequently associated with bleeding and abnormal crystals in the urine. Severe bleeding is quite rare with the other causes of renal colic except tubercle and growth of the kidney. Severe bleeding giving rise to colic is only occasional in tubercle, and then the ureter is somewhat narrowed and blood or debris cannot pass through the strictured tube. The following is an interesting example of tubercle of the kidney closely simulating stone.

Tuberculous Right Kidney and Ureter. Excision of Both.

Case 3.—A young man, Ernest Smith, aged 30. Admitted into Stephen Ward. About a month ago he came to the Front Surgery, suffering from right renal colic with profuse hæmaturia. The pain was very severe, and he was admitted into Stephen. Since then he has had several similar attacks, the pain being always very severe and the hæmaturia usually very profuse. There has nearly always been pus in the urine, and this has been examined for tubercle bacilli on several occasions with negative results. A guinea-pig injected also a few days ago. He has been examined with the X-rays for stone with a negative result. The

pain starts in the right loin and runs along the right ureter. He has a good deal of pain and frequency of micturition. When I saw him on August 10th, 1911, I could feel his right kidney to be both enlarged and unusually movable. Dr. French strongly advised exploration of the right loin, believing that there was a stone in spite of the negative result of the X-ray examination.

August 11th. *Operation.*—The usual incision was made in the right loin. The right ureter was felt to be greatly thickened and as hard as a pipe-stem, so that at first one thought there might be a stone in its upper end; but this hardness, swelling, and rigidity, extended down for several inches, so that it was clear that the swelling was inflammatory and probably tuberculous. It was, therefore, decided to shell the kidney out of its bed and bring it out into the wound. This was done without much difficulty, although the kidney was about twice the natural size. When its lower pole was visible it was seen to be studded with tubercle. It was gradually shelled out and delivered into the wound. The ureter was divided between two clamps, and the pedicle was transfixed and tied with two stout catgut ligatures, which were tied round the separate halves of the pedicle and then tied together round the entire pedicle. Then the wound was washed out with $\frac{1}{40}$ carbolic, and sutured with mass salmongut sutures, except for its posterior extremity where a rubber tube was inserted with a wick of gauze. The patient was turned over on his back after the wound had been dressed, and an incision was made over the lower part of the right rectus. The muscle was displaced inwards, and the peritoneum was also displaced inwards. The ureter was soon found and brought down and separated by blunt dissection as far as the bladder where it almost suddenly narrowed. It was clamped at this spot, tied and divided just below the clamp. This wound was entirely closed by mass salmongut sutures. The operation lasted about an hour and a quarter. The patient did not seem to be shocked afterwards. He was given continuous rectal infusion on his return to bed. He had a good deal of bronchitis during the first two days, but he was doing very well on August 15th, 1911, the urine being abundant and clear of pus.

August 20th, 1911.—Continued to do well. A little pus escaped from the posterior wound. The urine is clear and free of albumen. The patient was well two years later.

An X-ray examination should always be made, but a *negative report as regards stone in the ureter is not conclusive for many reasons.* A stone obstructing the ureter is usually small except when it is merely projecting into the ureter from the pelvis. The patients are often over middle age and somewhat stout. The stone may be composed of urates, which cast but little shadow. I have operated on at least ten cases and removed one or more stones from the ureter when the X-ray report was negative. In one case the patient had been radiographed five times at different hospitals, and I removed a stone the size of a filbert from the upper part of his ureter. In these cases cystoscopy is of the greatest value. Two grains of indigo carmine are injected into the thigh, and twenty minutes later coloured urine ought to be issuing from both ureters. The absence or diminution of the stream from one ureter is of the greatest significance, and the loin should be explored. In some cases a stone is seen projecting into the bladder from the lower end of the ureter. In others it can be felt just above the bladder through the anterior wall of the vagina. *A positive X-ray report more rarely misleads,* but I remember two instances where I was led to perform blank explorations. In one there were three stones in the branches of the internal iliac vein. These closely simulated stones in the lower ureter. In another a calcareous gland just above the crest of the ileum simulated high ureteral stones.

Pyelography is sometimes of value in the diagnosis of early hydronephrosis, and may help in deciding upon the cause. Diminution of urine during the pain with increase afterwards is suggestive of hydronephrosis. In these cases some swelling can generally be felt on careful examination. In some cases the pelvis can be felt independently from and internal to the lower part of the kidney. It is almost impossible to distinguish between an abnormal artery and a stricture or valve formation as a cause of early hydronephrosis, and exploration is the only certain way of ascertaining the cause and treating the condition. Occasionally, a movable kidney may give rise to pains which are indistinguishable from those of obstruction of the ureter, and yet the pelvis when examined is found to be normal. In one such case I found unilateral albuminuria associated with movable kidney, which was successfully supported by a belt for some time. Later the symptoms returned and I had to explore the kidney. No stone was found and the pelvis was not dilated. The ureter was not obstructed but the kidney was very movable and nephro-

pexy permanently relieved all symptoms. Bacilluria as a cause of renal pain is a common pitfall, for it is easy to be satisfied with the diagnosis of bacilluria when there is a real mechanical cause of obstruction which indirectly causes bacilluria. Case 4 is a good example of this. Five weeks were wasted under the mistaken diagnosis of bacilluria, when the real cause of the trouble was a stone in the ureter.

The pyelitis of pregnancy is always to be remembered and sometimes causes fairly severe renal colic associated sometimes with intermittent pyuria but rarely with hæmaturia.

CASE 4.—A lady, aged 50. The patient is a very stout lady who takes no exercise. About thirteen years ago she had an attack of pain in the abdomen, with a high temperature, and was ill for some weeks, and then completely recovered. She thinks the pain was then more to the left of the middle line of the abdomen. The attack did not follow childbirth. She had a good deal of trouble with the urine at the time. Since then she has had several minor attacks of pain, especially in the left flank, but she has never been laid up with them. As she motored from Ascot to Swanage a month ago she felt something shift in her left side with severe pain, and that evening she complained of severe pain in the lower part of the abdomen, with frequency of micturition. Dr. Baiss was called in and found the urine offensive and alkaline, and he diagnosed cystitis. The temperature was 102–103°, and the patient seemed very ill. She had rigors, and has had about six since. A surgeon from Bournmouth saw her with Dr. Baiss, and a catheter specimen of urine was sent to the Clinical Research Association on October 17th, 1912, and was reported to contain bacilli coli communis. A cultivation also showed this organism. Vaccine was suggested, but the patient was a little better, and the relations, therefore, decided not to have it. She seemed a good deal better for a few days, and then all the old symptoms recurred. This has happened several times, and a few days ago Dr. Paterson went to see her, and he suggested a further examination, and thought that the left kidney was probably at fault. The surgeon from Bournemouth had also noticed that there was tenderness in the left renal region and he thought that the left kidney was the chief part affected, but thought that the condition was due to an ascending bacillus coli communis infection and had advised treatment by vaccine. I saw her on October 26th, 1912, at 5 p.m., and could feel a firmness and a definite tender swelling of a fair size in the left renal region. This could be felt to fill out the loin from behind and there was also excessive resistance in front. The patient was still very stout and it was difficult to make out the size of the swelling. I advised cystoscopic examination, and carried this out under local anæsthesia after injecting indigo carmine (2 grains) into the thigh. The right ureter was normal and coloured urine issued from it after ten minutes, whereas none could be seen coming from the left ureter throughout the examination which lasted half an hour. The orifice of the left ureter was dilated, red, and inflamed, and there was cystitis around it and especially on the left side of the base of the bladder. There was no bleeding. No tumour, stone, or pouch could be seen. I diagnosed obstruction of the left ureter probably due to stone. In view of the patient's obesity and serious condition I did not advise the risk of waiting to get an X-ray apparatus down, but suggested an early exploration of the left flank. Dr. Baiss and Dr. Paterson agreed, but as the patient was a little better on the 27th her husband preferred to wait a little longer. The pulse had been bad during the most recent rigors and it was feared that she would not take any anæsthetic well, but when I was there the pulse was fairly good although the blood-pressure was low. Mr. P—— went to see Dr. Paterson on October 29th, and the latter strongly advised an immediate operation, but the patient was a little better during the next few days and was very reluctant to have an operation, and Dr. Baiss suggested trying the vaccine. This was prepared and the patient had two doses of it without any obvious effect. The temperature never settled down to the normal, being about 101° at night and 99° in the morning. She had very little pain, but got gradually weaker and somewhat thinner. Her temperature began to get higher again on November 7th and Dr. Baiss urged the necessity of an early exploration.

November 10th, 1912. *Operation*.—Dr. Rees gave the anæsthetic. Dr. Baiss and Dr. Paterson assisted. The usual oblique incision was made over the left kidney, which was very deep and adherent to its bed. It was also enlarged to two or three times the natural size. It was very difficult to shell it out, but at last this was done and a roll of gauze was passed behind it. The pelvis seemed to be distended and the ureter just below was also distended. There appeared to be a kink at the junction of the ureter and pelvis and I at first thought this was due to a band of fibrous tissue passing below

the junction, but on passing the finger down I felt a stone three inches down the ureter completely blocking the passage and causing a great deal of inflammation around with adhesion of the ureter to the fat. The stone was fixed so that it could not be pushed back into the dilated ureter above. The kidney was much inflamed, and contained many hard bulletty nodules, which were probably due to acute ascending suppurative nephritis. It was doubtful at first whether it ought to be saved. With a view of deciding upon the amount of kidney tissue left a trocar was introduced into the pelvis and drained away only about one ounce of turbid odourless liquid. It was therefore decided not to remove the kidney. After all the urine had been carefully mopped away a longitudinal incision was made over the stone and it was removed. It was quite small, granular, and very rough on the surface, conical, and dark brown in colour. A catheter was then passed down the ureter for some distance but it was impossible to pass it beyond the pelvic brim. A finger was passed along the outside of the ureter to the tip of the catheter, but there was no obstruction there. The difficulty was probably due to kinking only as the ureter was not dilated in this part. The puncture in the back wall of the pelvis was enlarged so that the finger could be introduced into it to feel the calices, but no other stone could be found. A tube containing a wick of gauze was placed behind the pelvis and the kidney was replaced after the wound had been thoroughly dried with gauze. The wound was then closed with mass salmongut sutures. The patient stood the operation, which lasted nearly an hour, fairly well. She was rather shocked afterwards, but one pint of saline containing thirty grains of aspirin restored her. She had a good deal of pain and was given one-sixth of a grain of morphia after the operation and she slept for two hours. Her pulse which had been 110 before the operation was down to 88 by 5 p.m. on the day of the operation, and her temperature which had been 102 was normal at 5 p.m. She was given half a pint of rectal saline every two hours after the operation.

The patient gradually made a good and complete recovery and has remained quite well since, the urine being normal.

Case 5.—A lady, aged 55. The patient is a very stout maternity nurse. When she was a little girl she had inflammation of the bowels, and was very ill for a long time. Six years ago she had acute severe pain along right ureter. Three years ago she had an acute attack of pain in the left flank lasting a few hours, and then she was quite well again. Early on the morning of February 22nd, 1914, she was seized with violent pain in the abdomen, and did not sleep again that morning. She has hardly slept since then. She had a great desire to pass water, but on trying to do so she passed no urine but only four drops of blood. She had very slight hæmaturia again the next day. The pain has been very severe, and ran down from the left loin into the left groin and across the middle line towards the appendix. She has vomited a great deal. The bowels have acted with medicine. The pain has been relieved by opium. She is never quite comfortable, and the pain returns in spasms. She has passed very little urine since February 22nd, not more than five or six ounces in twenty-four hours, and sometimes less. She was getting worse on February 26th and 27th, and Dr. Ransford became very anxious and had her moved to 3, York Place, W. When I saw her on February 27th at 5.30 p.m., the abdomen was greatly distended. She was very tender in the left flank, and especially in the left loin. There was also some tenderness in the right iliac region, but the abdomen moved pretty well. A catheter only withdrew an ounce of clear, slightly albuminous urine, although she had passed none since the early morning. She was sick as I was seeing her, and became very short of breath and blue. The journey had upset her a good deal, although she came in an ambulance. I decided to let her wait until the following morning, thinking that she would be better able to stand an operation. A diagnosis of calculus in the left ureter was made, the other kidney having been destroyed by complete obstruction of the ureter six years ago.

February 28th, 1914, at 9 a.m. *Operation.*—The patient was better. Cystoscopy showed a dilated, round, left ureter. The right seemed normal, but nothing could be seen issuing from either. The left loin was explored at once, and the kidney was found to be greatly enlarged. The tissues around were very œdematous and hæmorrhagic. The hand was passed below the lower pole towards the pelvis, and there discovered a small stone acting as a ball valve. A knife was passed, shielded by the hand, into the depth of the wound, and a longitudinal incision was made over the stone, which was easily withdrawn with the fingers. A tube was placed in the loin, and the wound was closed with mass salmongut sutures. The operation lasted about fifteen minutes only. The patient was infused four pints during the day, and

within seven hours she passed five pints of blood-stained oily urine of high specific gravity. None escaped through the loin. As the bladder was very small, the patient was almost constantly passing urine, and some was lost owing to the urgent and violent strangury. The patient, although apparently conscious, remembers nothing of her first few days at the nursing home. She rapidly improved, but occasionally complained of pain along the course of the left ureter.

On the 10th March, left renal colic and suppression developed, and no treatment seemed of any use, therefore an operation was advised. As the pain and tenderness were lower down and in front, an anterior incision was made.

March 11th, 1914. *Operation as before.*—Dr. Depree gave the anæsthetic and my brother assisted. An anterior incision was made, the rectus muscle and the peritoneum being displaced. A very small stone about the size of half a pea was found in the ureter, which was completely blocked. The stone was removed, and the patient stood the operation as well as could be expected. She was infused with two pints into the axillæ immediately after the operation, and she gradually made a complete recovery.

This case raises the question of the *treatment of calculous anuria.* Some of you may remember Mr. Lucas's brilliant operation for this condition some thirty years ago. He showed the patient at two International Congresses in London at an interval of thirty years, and she was very well when last shown. He had removed a kidney which was pyonephrotic and had been spoiled by many calculi. Some years later the patient had anuria, and Mr. Lucas successfully removed a stone from the ureter of her only kidney.

I remember another patient whose kidney was removed by Sir Arbuthnot Lane for tuberculous disease. A few years later she was admitted into another hospital for anuria, and allowed to die without exploration, under the impression that the opposite kidney was tuberculous and suppressing. At the autopsy a stone was discovered in the ureter.

The rules for calculous anuria are —

1. To operate as soon as possible after the diagnosis is established, for long delay may lead to fatal suppression in spite of removal of the obstruction. It is uncertain how long the obstructed kidney may remain recoverable, and this probably depends a good deal upon the completeness of the obstruction. In my case the obstruction was not complete at first, a few ounces of urine being passed on several occasions. The chances of recovery after five days of complete obstruction are poor, but we should not wait so long.

2. It is best to operate on the side of the recent colic. Exploration of the other side may reveal only a withered or hydronephrotic kidney.

3. In the absence of definite evidence as to the position of the obstruction such as an X-ray shadow of stone, or a view of the stone projecting into the bladder, or palpation of it in the vagina, it is wise to explore the loin for the chances are that the stone can be reached from the usual oblique incision in this region. In any case a catheter can be passed down the ureter to locate the stone, and often a stone may be backed into the dilated part of the ureter. If the patient is too ill for anything more to be done, his life can be saved by draining the pelvis of the kidney, and a stone near the lower end of the ureter can be more safely removed at a second operation

University of London Officers' Training Corps.

Medical Unit. "B" Section.

1. Cadets are reminded that in order to become efficient they must (*a*) attend twenty drills (unless they have already done "B" certificate); (*b*) be present at inspection on June 27th, and (*c*) go to camp for one week.

2. Anyone unable to be present at inspection must get leave off *before* the day. To do this he must apply to me in writing, stating reasons, in time for me to investigate these reasons, and to forward the application to Headquarters before the day of inspection. Medical certificates, excusing cadets from inspection, must also be forwarded before the day of inspection, and no excuse of non-attendance will be considered after inspection is over.

3. *Cadets are warned that they will not be allowed to attend camp if they are already inefficient through absence from inspection and non-attendance at drills.*

4. Drills are now held weekly at Millbank on Thursdays, at 5 p.m. Everyone should make it a point to become thoroughly acquainted with stretcher drill before attending camp.

5. A practice for inspection will be held on Saturday, June 13th. All cadets who have not previously been to inspection should attend this drill.

6. The attention of men in the wards is drawn to the following regulation of the school as regards holidays:—

> "Students who are members of the Territorial Force or the Officers' Training Corps shall be permitted to count their two weeks in camp as one week. In alloting holidays preference shall be given to Territorials going into camp."

They should, therefore, apply for leave on July 1st, from the members of the staff, and the registrar under whom they are to work during the ensuing quarter.

Guy's Hospital, S.E.,
May 19th, 1914.

T. B. LAYTON,
Lieut., R.A.M.C. (T).
O.C. "B" Section

Obituary.

PERCY WARNER,

Of Woodford Green, Essex. April 1st, 1914.

IT would be a loss to the roll of medicine if he, whose name heads this notice, were to pass away without some honourable mention, some words of well-merited appreciation. For Warner was no ordinary man. During 30 odd years of professional activity he was ever and always a worthy son of his old school, imbued with its spirit, devoted to the personality and memory of Samuel Wilks; living his life under such ideals, yet transforming them by his own breezy affectionate nature; and thus planting his own memory deeply and tenderly in the hearts of those to whom he ministered, and of many, many a friend.

Warner was not originally intended for the study of medicine. Coming of good old Hampshire stock—Fareham was his home—he was educated at a naval school at Southsea, for the Navy, but, when the time was ripe, there being some difficulty about a nomination, he was entered on the rolls of H.M.S *Worcester*, then lately given over by H.M. Government for the training of cadets for the Merchant Service. Here at the end of his course, in addition to other prizes, he came out first of his year in 1868, with the Queen's Gold Medal, a distinction that, in his case, procured for him the appointment of 3rd officer in his first ship, instead of, as was usual, being taken on as an apprentice. It was while on board the *Worcester* that he became acquainted, if not friendly, with the future Admiral Togo, who was about that time also a cadet on board, and it was one of the disappointments of one of his later illnesses that he was prevented from attending a public dinner, given in London, in the Admiral's honour, and shaking hands with his old comrade, now become so very distinguished a man.

Three interesting years young Warner served in a sailing vessel—*The Lothair*—one of the fast clippers that then plied between China and Japan, and London and New York, with the first season's teas, and on one occasion he nearly suffered shipwreck. He afterwards passed the Board of Trade examination for second mate, and entered the service of the Peninsular and Oriental Steamship Company, where he rose from fourth to second officer, becoming familiar with the trade of Bombay, Calcutta, Ceylon, and the Straits. It is probable that the sea did not quite satisfactorily absorb the power that lay within him, and that he found it in some respects uncongenial. Leaving that service, therefore, in 1877, he decided to devote himself to medicine, and he joined the Medical School of Guy's Hospital in the summer of that year. His new pursuits were obviously to his taste, for entering in a year that was remarkable for the number of those who have since distinguished themselves, he was one of the first men of his time. Always hard-working, always reflective, always pre-eminently reliable, he was one in whom teacher and patient alike confided; he obtained the Treasurer's Gold Medal for Medicine at the end of his course as well as other prizes, one being the Physical Society's first prize for an essay upon "Chronic Rheumatic Arthritis." Leaving the Hospital in 1882, Warner settled at Woodford, practising, at first, for some years in partnership with Dr. Turtle, and from that time onward, he the physician and Woodford his sphere, became ever more and more intimately linked together, so that it became difficult to conceive of the one without the other. In this, too, he was substantially aided by a very happy marriage with one who was in full sympathy with all his aims and whose ever growing influence was of the greatest help and support to him throughout his life. Into the intimacies of this home life we may not enter, but let this suffice that in saying goodbye to two of his old friends within what proved to be an hour or two of his death, he said: "They tell me I have reached my last lap, well! I have had a happy life." And there was nought of the visionary in this.

In his relations with his patients it may be said that some thing of the sailor still surrounded him. Even in appearance he seemed to bear something of the ruggedness of the weatherbeating sea, and he had the frankness, the warmheartedness, and breeziness of manner, that made him the friend and beloved of all. One who knew him long in all aspects writes of him: "He seemed to carry with him the message 'be of good cheer,' there was always a blithe aspect in his salutation; he was tender and true, genial and strong."

Yes! he was possessed of that ineffable attribute *strength*. Hard it may be to define, but knowledge, judgment, sympathy, courage, decision, determination, all in one, irradiating the man, and bringing repose and confidence to the sick and the anxious.

His views of life, and of the many problems concerned therewith, confronting all who study medicine, were always well informed and well considered. One never found him rushed by the latest fad; he waited till the cream had risen to the top before proceeding to skim it. He was probably more inclined to be the physician than the surgeon; nevertheless, he was surgeon to the Woodford Hospital, and he was not averse to operating when occasion demanded it, and often did so there and in private with notable success. Moreover, as one of his old comrades tells, he was always on the look out to learn, and he was a great help to others when operating by kindly advice and suggestion, and in the confidence that he inspired.

Such an one was he to his patients, but he was more than that. He was a man of letters with whom it was a delight to talk, and from whom one was always learning. His odd moments were given up to literature, and there was generally the half-opened book somewhere in his carriage into which he was dipping between his visits. He was steeped in the English Classics, and he founded a Literary Society at Woodford, of which he was the president for many years,

There are many who remember with delight his interesting papers on Scott and Wordsworth, Burns,

Hogg, Keats, Crabbe, Carlyle, and Oliver Wendell Holmes. It had, indeed, been suggested, and it was hoped by many, that some of these might have been published in some intervals of leisure to come that, alas, the future did not deign to bestow upon him. He was thus a valuable ferment in the lives of others; he was, besides, an active man in his parish. He was keenly interested, also, in starting and working the Woodford Hospital, at the opening of which he was present in 1899, when he had only just convalesced from a severe illness. He had been president of the Walthamstow branch of the British Medical Association, and during his tenure gave an interesting address on his past experience, entitled "After Twenty Years."

As regards holidays, he was fond of a day's shooting, and occasionally got one in the season. In the last year or two of his life he had acquired a small cottage at Quendon, in which he took great pleasure, and seemed to derive fresh energy and inspiration from the rest, the garden, and the country air and scenes. But he did not until latterly allow himself many days off, except a not too long vacation, when he would roam with his wife and family, sometimes in the land of Scott, and again in that of Carlyle or of Burns, or in some other historic neighbourhood, perhaps abroad, but in addition to the scenery and change always investigating the history of the locality, as it might illumine the writings of the great men of the past, and add interest to his own studies and reflections. Wherever he went he made friends of the best among the educated and cultured, as well as among the lowly and unlearned, and it has been said by one who knew him well that few Scots had such an intimate and friendly acquaintance with, or such an appreciation of Scotland, or of Scottish life, as had Percy Warner.

As to the defects of his character. Well, we do not know them, nor does Woodford where he laboured for a generation. No doubt there were some angles and depressions in the contour of his vitality—the world would be but a big birdcage without them—but what is certain is, that during a long, disappointing, and wearying illness, he was never irritable, never murmered, and that he died with those words almost upon his lips, "I have had a happy life." Dear friend be sure of this: To memory you are dear though lost to sight. Of you it may be truthfully said, that your influence upon your environment was so intimate, now that it is withdrawn, there will be something wanting in Woodford for all those who have been in any way associated with you, until they rejoin you in the great Unknown. And in this light we may judge you to have been peculiarly happy in your death.

During his last illness he had beguiled his hours by writing some "Thoughts on the French Revolution." He was ever an admirer of Carlyle. These he had submitted to the judgment of a friend. To his surprise and evident pleasure his manuscript was returned to him printed and bound, very beautifully so, with the following *apologia* as a preface, signed by a number of his "grateful friends." No apology is needed for reproducing it, for no more touching and beautiful tribute to his abiding worth can be imagined:—

> "This book of yours needs no defence, and none is offered here for its public appearance, but we hope you will pardon the liberty your friends have taken in sending your literary offspring into the world without your protection and guidance, even without your consent. But being a healthy child and already assured of a warm welcome among those who count your friendsh ip one of their most precious possessions in life, he will do his work among them. If he returns to you somewhat changed in form and feature, he is still your own, and the bearer of their loving mes sages to you, who through so many years have been their guide, philosopher, and revered friend. You have been a tower of strength to them in days when human nature lay weak and unadorned beneath your practised eye, when to—
>
> 'Stop change, avert decay,
> Fix life fast, banish death,'
>
> was the work y ou gave *yourself* to do.
>
> "You taught them in happier days that
>
> . . . life is—to wake, not sleep,
> Rise and not rest, but press
> From earth's level where blindly creep
> Things perfected more or less
> To the heaven's height far and steep.
>
> "And now they bid you fight on with the courage of one who never doubted clouds would break, and after all these weary months they pray that God may give you back to them and to your own."

What an heirloom to leave behind him! But it could not be. It had been, and was with him:—

> "No time for rest, till glows the Western sky,
> Whi le the long shadows o'er our pathway lie,
> And a glad sound comes with the setting sun—
> Servants, well done."

He was buried at Chigwell Row on April the 4th, and seldo m, if ever, within living memory has Woodford witn essed such a company of sad and sympathising mou rners.

Papers by Guy's Men.

R. A. Chisolm, M.D., B.Ch.: Case of Spastic Diplegia.—Proc. Roy. Soc. Med., Sect. for Study Dis. in Child., April, 1914.

Philip Turner, M.S., F.R.C.S.: Case of Multiple Exostoses.—*Ibid.*

Hildred B. Carlill, M.D.: Case of Spastic Smile with Tremor of the Upper Extremity and Defective Articulation.—*Ibid.*, Clinical Section, April, 1914.

W. Johnson, M.D., and W. M. Mollison, M.C., F.R.C.S.: Case of Left-sided Cerebello-pontine Lesion, probably Tumour.—*Ibid.*, Sects. of Neurol., Ophthal., and Otol., April, 1914.

John Fawcett, M.D., and A. W. Ormond, F.R.C.S.: (?) Syringomyelia involving Bulb; Bilateral Nystagmus.—*Ibid.*

R. H. Jocelyn Swan, M.S., F.R.C.S.: Tumours of the Urinary Bladder.—*The Lancet*, May 9th, 1914.

Guy's '89 Club.

The Nineteenth Annual Meeting and Dinner took place on 13th inst., at Cecil Hotel, Mr. R. H. Fagge, President, in the chair. The following members also were present: C. E. Michael, C. H. Fagge, W. E. Robinson, F. J. Steward, John R. Steinhaeuser, J. Moore, B. Gore Reynolds, L. G. Reynolds, C. A. Ensor, H. W. Collier, G. L. Eastes, H. M. Stewart, A. A. H. Partridge, C. D. Edwards, W. H. Jewell, C. E. Carpmael, A. C. Hovenden, W. J. Henson, E. T. Shorland, J. W. Ensor, H. W. Beach, W. S. Handley, and H. J. Spon. The officers elected for 1915 are: President, W. S. Handley; Vice-President, E. T. Shorland; and Secretary and Treasurer, H. J. Spon (48, Queen Anne Street, W.).

Great regret was felt at the absence (through illness) of E. F. H. Hardenberg, a past president and secretary of the club, and of others who were unavoidably prevented at the last moment from attending the re-union, which was, otherwise, one of the most successful of recent years. It was suggested that a Golf Foursome Tournament should be held in 1915, at a London Course, on the same day as the Dinner, viz., May 12th, and the Secretary would be glad to hear from those members willing to take part in such an event. Will all members, especially those resident abroad, again note that, by a resolution passed at the Meeting, held at "Jimmy's," on March 8th, 1899, the Dinner is fixed to take place upon the second Wednesday in May.

The Need for Organization in the Nursing Profession.

By Miss MARGARET ATKEY.

It is now about half a century since educated women were admitted to our Hospitals and Nursing Institutions and accomplished the revolution in the care of the sick which has now become a matter of history. In those early days of struggle and achievement trained nurses were necessarily so absorbed in the fight against dirt, neglect, ignorance, and prejudice, their work was so strenuous, the strain of continuous bodily exhaustion and mental restriction so great, that they had little opportunity of realising what other nurses were accomplishing, or of knowing how the warfare prospered in any sphere but their own.

With the dawn of the 20th century new forces began to make themselves felt. Nursing papers became more widely read, here and there nurses' leagues and clubs were formed, and there came into existence amongst the more forward women in the nursing world a spirit of conscious unity. But still the great mass of nurses in the country to-day are unconscious that any effort is being made to bring the various sections of their great profession into touch with each other, and they do not realise that co-operation is daily becoming more necessary if we are to move onwards and take our place in the history of this century.

Let us for a minute consider how we as nurses stand in relation to the life of the community to-day. The trained nurse becomes daily more indispensable, she is seen wherever men congregate, and I suppose no class of workers is more often in people's mouths—idolised, condemned, admired, and criticised in turns. She has come down off the pedestal which she adorned in the last century, and is regarded by the man in the street more as a good fellow than as a plaster saint.

To us Matrons who know her best, the average nurse is a lovable, sincere, unselfish, but unbusinesslike person, apt to concentrate on what lies immediately before her and unconscious of what is going on outside her own work; she shows herself short-sighted on some occasions and splendidly devoted and efficient on others. Now, as we are all faulty human beings, it is, perhaps, the easiest course to appreciate the virtues and ignore the failings of the modern nurse, treating them as the inevitable manifestations of human frailty. But it is at Conferences such as this that the opportunity arises for us to consider whether something cannot be done to produce a more even-minded, complete, evolved type of woman, better fitted for the enormously widened opportunities of to-day and capable of taking a higher place in the life of the comunity.

Surely if we set ourselves to the task we might unite the ideals which carried the nurse of the 19th century so far—the spirit of self-sacrifice and devotion to duty—with the broader outlook, greater tolerance, widened sympathies, alerter minds, which are to be found in the best type of woman to-day.

The average nurse enters her training school more or less as raw material. She has good intentions and is prepared to be trained, that is to say, to be moulded to any shape required. In most cases she absorbs certain nursing standards which become part of her character; she is taught to be quick, punctual, orderly, and loyal to those in authority. She also becomes very proud of her hospital and feels a comradeship with all nurses trained there, but she seldom has any sense of fellowship with other nurses; on the contrary, she feels some satisfaction on hearing of the shortcomings of nurses from other training schools, and it does not occur to her that all nurses stand or fall together. For instance, a new Matron is appointed to, let us say, a Convalescent Home in a fair-sized town. She is an utter stranger and is, perhaps, in servant difficulties, or wants advice about tradesmen. The very last person she would think of asking for help is another nurse. The Matron of the General Hospital, whose patients are transferred to her care, does not call upon her, and any communications between them are of the most distant kind. Private nurses living in the same town never speak to each other, and regard each other askance when they chance to meet, while nurses at Institutions treat each other as rivals, or at any rate would never dream of trying to make their work dovetail with that of others.

(To be continued.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Museum Demonstrations.

DEAR SIR,—May I suggest that Museum Demonstrations be given at Guy's by the Staff of the Medical and Dental Schools.

The great success of the demonstrations now given by official guides at the principal London Museums and Picture Galleries leads me to hope that the treasures of Guy's Museum may be made known to students of the Hospital in a similar manner.

It would be presumptuous to suggest a scheme, but perhaps some of the demonstrations might take the place of clinical lectures, and the tour of the whole of the museum made during each session.—Yours faithfully,

May 11th, 1914. EDUCATION.

Dear Sir,—May I venture to appeal through your columns for votes and interest for Wilmot Eaton Milward, aged 10, for the next election to Epsom College.

The late Dr. Milward, who died so suddenly, was an old Guy's man, and Mrs. Milward is an old Guy's nurse.

Many of your readers will recall their recent kind support of the "Milward Fund" which realised over £1,300.—Yours faithfully, WILLIAM SHEEN.

2, St. Andrew's Crescent,
Cardiff.
May 18th, 1914.

Lawn Tennis.

DEAR SIR,—I have been asked to send in to you the results of the Second Tennis VI. matches this year to be published. The following match played on Saturday, May 9th, at Honor Oak Park, againstWallington, ended in a win for us by 6 matches to 3.

N. Garrard and C. E. Petley beat R. E. Piper and R. D. Good, 6–3, 6–4; beat B. Valentine and F. Acroyd, 6–2, 6–4; beat A. C. Rickett and A. S. Dennis, 6–2, 6–1. Woodruff and R. Sells beat R. E. Piper and R. D. Good, 7–5, 7–5; lost to D. Valentine and F. Acroyd, 5–7, 2–6; beat A. C. Rickett and A. S. Dennis, 6–4, 6–3. A. K. Day-Lewis and N. Minns lost to R. E. Piper and R. D. Good, 1–6, 6–3, 4–6; beat D. Valentine and F. Acroyd, 7–5, 9–7; lost to A. C. Rickett and A. S. Dennis, 1–6, 3–6.

The College, Yours truly,
Guy's Hospital, S.E., R. SELLS.
May 20th, 1914.

Pass List.

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

FIRST PROFESSIONAL EXAMINATION, MAY, 1914.

Mechanical Dentistry and Dental Metallurgy.

*Allen, N.	Martin, P. R. C.
‡*Batsford, J. F.	Monk, G. B. F.
Barfoot, W. P.	*Moore, R. A.
Broom, G. F. H.	†Morris, L. A.
*Crook, F. W.	‡*Parkes, H. P.
*Danks, G. H.	†Payne, A. L. S.
Deeks, G.	Penfold, W. D.
†Deverall, E. P.	Pennant, G. A.
†Fox, F. L. H.	*Pretorius, W. J.
Hallett, L. R. J.	Thomas, G. M.
Hawkins, C. F.	‡*Thom, M. C. V.
Hodgkinson, R. J.	*Vogt, H. V.
‡*Hugo, P. J.	Watson, M. G.
Lean, F. C.	‡*Wilshere, R. G.
†Lloyd, O. O.	‡*Woolf, S. A.
Martin, C. R.	

* Mechanical Dentistry only. † Dental Metallurgy only.
‡ Denotes completion of examination.

FINAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY, MAY, 1914.

Parts I. and II.

*Beacock, J. W.	*Dyke, V. R.
*Clewer, D.	*Whitten, M. G.

Part I. only.

Allan, W. J. M.	Lowein, A.
Bevis, D. A.	Machin, L.
Coe, W. E.	Millett, H.
Corke, T. D.	Pilbeam, L. S.
Dean, A. C.	Rudd, F. E.
Duggan, H. C.	Ryland. R. J.
Garrard, J. L.	Spong, R. W.
Jessop, P. E.	Welton, F. E.
Lloyd, W. G.	Withers, S. A.

Part II. only.

*Cole, A. H.	*Pearson, M.
*Crocker, C. J.	*Pickett, R. J.
*Cutts, G. L.	*Salt, H. O.
*Donn, R. L.	*Rycroft, E. C.
*Edwards, H. J.	*Stebbings, J. M.
*Hammond-Williams, W. C.	*Warner, N. S. H.
*Johnson, S. E.	*Wright, J. E.

* Denotes completion of examination.

Marriage.

DUNDERDALE—QUIN.—On February 16th, 1914, at Mombasa Cathedral, East African Protectorate, by the Rev. S. A. Martin, Geoffrey Dunderdale, M.D., B.S. Lond., East African Medical Service, son of the late W. J. Dunderdale of Kirkheaton, Yorkshire, to Gertrude Mary, daughter of the late Ed. S. Quin, of Cappoguin, County Cork, Ireland.

Death.

PILCHER.—On May 3rd, 1914, of enteric fever, at Marseilles, on her way home from India, Mabel Elizabeth Pilcher, of Godalming, late Lady Superintendent, Mayo and Albert Victor Hospitals, Lahore. Guy's Certificate, 1909.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 677.] JUNE 6, 1914. [SIXPENCE.

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Passim.

THE concluding half of Miss Atkey's interesting and stimulating paper on "The Need for Organization in the Nursing Profession" appears in this GAZETTE. We cordially agree with Miss Atkey in her advocacy of this very important step in the evolution of nursing from its present chaotic state to the standing of a well-ordered and recognized profession with a definite status, and a definite code of ethics.

The problems which agitate the best minds in the nursing profession also concern our profession, both directly and indirectly. Chiefly, we are concerned with the question of the education of nurses in their work, and this aspect of the matter is one which deserves more thought from the profession than it usually receives. It is our constant ideal to obtain for each one of our patients the best treatment available. In very many instances we are helpless without the co-operation of an efficient nurse. But at present we have no means available by which we can tell whether a given nurse is efficient or not, or even whether she has been properly trained, until we have had actual experience of her work. Her training certificate is, in many instances, of little or no value. Some schools grant certificates at the end of one year, others after two, three, or four years. In some schools the training is excellent, at others it is hopelessly inefficient. There is no standard of uniformity anywhere. It is obvious that such a state of affairs is bad for all concerned, patient, doctor, and nurse.

To the nurses themselves it is especially harmful since it effectually prevents co-operation among the graduates of different schools. They look askance at one another as we are accustomed to look at the graduates of certain foreign schools of medicine. The remedy for this state of affairs seems obvious to one totally ignorant of the inner difficulties and complexities of the matter. The establishment of a Central Nursing Council, with power to enforce a definite standard, and as a corollary some form of registration would go far to remove the anomalies. Some such body will undoubtedly be created eventually we have no doubt. We can only hope for the sake of the nursing profession that it will not be the General Medical Council. That body would totally destroy the nurse's small independence and make her a voiceless machine.

WE publish in this issue the first list of acceptances for the forthcoming Biennial Dinner on Friday, July 3rd. The number of intending diners is already a long one, but there are still very many Guy's men who *can* and *ought* to come who have not made up their minds. There are also, doubtless, many who intend to come, but who have not yet sent in their names. We would impress upon this latter group especially the importance of letting their names appear in the next list of acceptances, as it is the thought of seeing old friends which will decide the waverers, and finally induce them to come also.

This is the age of records and of breaking records. Whether the symptom is one of good or evil omen for the world at large we leave to the historians of the future to determine, but it is certain that there is one record at least which is only made to be beaten at each successive attempt. The attendance at the Biennial Dinner in 1912 constituted a record which must and will, we have no doubt, be beaten this year. Therefore, we would impress on every Guy's man the importance of his presence at the Dinner this year, and further the importance of inducing his contemporaries to attend also.

As we noted earlier in the year the dissolution of the London Post-Graduate Association has set the School free from restrictions upon its post-graduate teaching, and as a result a special course has been held during the past three months for the F.R.C.S. examination. A brief review of this course may be of interest. The Classes were under the direction of a specially appointed Clinical Tutor, who co-ordinated the work of the various sections, and was assisted by the Surgeons and Assistant Surgeons on both the general and the special sides of the Hospital. The hours were so arranged that all the work of the class was got through on four afternoons in the week, leaving the mornings free for other or additional work and reading. This arrangement worked well in practice and was very popular with the men who attended. In each week one demonstration on a selected subject, or on selected cases, was given by both a general surgeon and one in charge of a special department. A special feature of these demonstrations was the number of good cases shown, and it was obvious that great care had been taken in their selection.

Two demonstrations in Pathology were given each week by Mr. Davies-Colley, and these were supplemented in the latter part of the course by demonstrations in Morbid Histology, by Dr. Nicholson. Two afternoons in each week were devoted to Operative Surgery. The course in this subject was very complete, and the syllabus, which was worked through systematically, enumerates over 140 operations.

Ten test-papers were set, one in each week, and each member of the class received his paper back corrected and annotated together with a typewritten outline answer to the question. This was unquestionably one of the most valuable features of the course and appreciably increased the efficiency of the class in writing their papers to the best advantage.

Finally, three demonstrations on selected cases were given by the Clinical Tutor each week. The cases shown numbered about one hundred and fifty and were selected from all the departments in the Hospital. They were in many instances cases which the man working at surgery by himself would never see since they were not in the surgical wards, or at surgical out-patients, but were chiefly found on the medical side or in the massage or electrical departments. The course more than justified its existence in this aspect alone as the selected cases were all of them of great interest and revealed a quite unexpected wealth of clinical material which is ordinarily wasted.

The whole course was, we are convinced, a very valuable one, and will, we hope, be continued on the same lines in the future. The results at the recent examination were also very excellent and afford encouragement for further efforts. Eight men who attended the course completed the examination, and exactly half of them were successful. The average pass for the whole examination was also just 50 per cent.

The Librarian would be glad if all those volumes which have been borrowed from the Wills Library and retained for some considerable time were returned at once. He would be especially glad if the borrower who took away the copy of Beattie and Dickson's General Pathology some months ago, and apparently forgot to write his own name on the borrower's slip, would return this volume at once, as its absence is causing annoyance to other men.

We cordially endorse the Librarian's request. In the vast majority of cases the books are retained, not because they are in use, but simply because the borrower is too careless and too

forgetful to return them. If he will recall his own annoyance at the continued absence of a book he wishes to consult, perhaps he will have a little more consideration for the feelings of others.

TO-DAY (Saturday, June 6th) the Athletic Club hold their Annual Sports on the Ground at Honor Oak Park. They commence at 2.30 p.m., and Mrs. Hertz has kindly consented to distribute the prizes later in the afternoon. We hear that the number of entries is well up to the mark and that some very keen contests are expected. It is to be hoped that there will be a large attendance of spectators to cheer the competitors on.

THE following account of the onset of typhoid fever as described by a Chinese clerk is not without interest. It is evident that the doctor has considerably enhanced his reputation locally by his timely appearance :—

"DEAR SIR,—I beg to inform you that my brother Tsu Tsung Ziang interpreter in your office, for sickness, has not attened his duty for 4 days. Please excuse me for late information. He has been attacked by diarhea last week. On Sunday morning he felt a little annoying and headache, till noon when the servant was calling him to take dinner, he refused and without an instant the contents of the stomach rushed out from above and from below, and his complexion instantaneously became pale, wan and fearful. Soon the coldness of the four limbs followed and the blood flowed slow. Doctors were sent for and in vain. Family were in sixs and sevens condition. The faltering cry was echoed and re-echoed but the sick man was sleeping.

"At about seven in the evening, all what vitality left in him were that his heart a little jumping and a little warmth. Everyone was capecting his last breath, none was thinking that he could enjoy with us to day. At this critical moment the door was knocked hard and Dr. Daung stepped in and this doctor was his saviour. He bleeded him and gave him brandy. Half an hour passed the sick man began to have pus and the limbs began feel a little warm. At present Dr. Daung is curing my brother, and the sickness seems somewhat like typhoid fever. He is at present unable to attend his duty in hopes that you will be kind enough to grant his absence.—With best regards, I am, yours truly,

Ralph Wingent Memorial Fund.

SIXTH LIST OF SUBSCRIPTIONS.

	£	s.	d.
T. E. Ashdown Carr, Derby	0	5	0
Hal. J. Henderson, Amersham, Bucks ...	0	10	6
Claude H. Mills, Cavendish Place, W. ...	1	1	0
G. T. Mullally	0	10	6
A. S. Morton-Palmer, Worthing	0	7	6
J. T. Smalley, Hong Kong	0	10	0
	3	4	6
Previously acknowledged (May 5th, 1914) ...	28	9	0
Total	£31	13	6

H. C. MANN,
P. S. PRICE,
Hon. Secs.

June 3rd, 1914.

Obituary.

Dr. P. H. PYE-SMITH, F.R.S.

WE regret to have to record the death of Dr. P. H. Pye-Smith, F.R.S., our Senior Consulting Physician, which occurred on Saturday, May 23rd, in his 75th year.

Dr. Pye-Smith retired from the active staff fifteen years ago, and has been a confirmed invalid for the past five years, and hence the present generation of students is not familiar with his personality.

He joined the Hospital in 1859, and in 1899, on his retirement from the active staff, he was appointed Consulting Physician, and throughout his connection always proved himself a most active and valued member of the staff.

He took a degree with Classical Honours in 1858, and throughout his life continued to keep up his interest in and acquaintance with the classics, as was well shown by the numerous quotations from the old writers with which he prefaced the chapters in Fagge's medicine.

As a student he had a very distinguished career at the University of London, taking among other distinctions the Gold Medals both in Medicine and in Surgery at the M.D. Examination in 1864.

He then went abroad to Paris, Berlin, and Vienna, returning in the following year to teach Comparative Anatomy, which he continued to do for ten years, and for four of these years he was also Demonstrator of Anatomy, having Dr. Fagge and Mr. Bankart as his Senior Colleagues.

In 1870, he was appointed Medical Registrar, and in the following year Assistant Physician. For ten years he lectured on Physiology. His interests were thus very wide, and he was throughout his life brought into close relationship with other Zoologists and Physiologists, many of whom formed ties of close friendship with him.

Dr. Pye-Smith was an excellent lecturer, he was methodical and accurate, with a good command of the English language, a skilled draughtsman, and as he devoted much time to the preparation of his lectures he always set before his audience a full and accurate exposition of the subject under discussion.

In appearance he was slightly built, alert in his manner, neat in his dress, and as he was punctual and regular in his attendance at the Hospital, his was always a well-known figure in the Colonnade.

He especially excelled on ceremonial occasions, and as an after-dinner speaker he was unsurpassed by anyone in the profession. A cultured mind, a happy turn of words, a well-selected quotation and a good presence combined to render his light speeches delightful.

He represented his school and his profession with distinction on many occasions. He was an active member of the College of Physicians: he served many offices, and gave the Lumleian Lectures in 1892 on the "Ætiology of Disease," and the Harveian Oration in 1893.

He was the Vice-Chancellor of the University of London for two periods of office, and was one of the most influential members on its Council.

His short "Introduction to the Study of Skin Diseases" was a masterly production, and he added many valuable chapters and references to the four editions he brought out of Fagge's Text-book of Medicine, but he was not otherwise a very voluminous writer.

As a teacher he inculcated method and accuracy, and was very severe on students who guessed or fancied a sign might be present for which there was not sufficient evidence.

He helped greatly to clarify and reduce to system the nomenclature of skin disease by insisting on the accurate use of terms, and his teaching was of great value to a long succession of students.

Being himself naturally generous and unselfish, he greatly disliked any action suggestive of self-seeking or advertisement, and he was not slow to express his opinion of such.

His fine and upright character could not fail to leave its mark on the Hospital and School with which he was so closely associated for forty years.

Dr. Pye-Smith.

An Appreciation.

THE passing of a man who once wielded a strong influence amongst us deserves more than a mere record of his work. In Dr. Pye-Smith we lost, when he retired from the active service of the Hospital, a leader difficult to replace, a teacher who devoted himself to the interests of the School, and a physician who, in his time, not only kept up the fame of the Hospital, but contributed to the general literature of medicine in no small degree.

The record of his work will be found in the notices in the medical journals, to us at Guy's there is a more intimate history, and one needs to have been a pupil and a colleague to appreciate the full value of his services to the Hospital and the School.

In this brief note one can but touch on some of the many services he rendered during his long connection with our active life. I first came under his teaching in 1872—3 when he took the classes in comparative anatomy for the Preliminary Scientific of the London University and also lectured on this subject. His teaching was based not only on the study of specimens collected by others, but on the results of sea dredging he had conducted himself. He was in touch with Huxley and the other foremost men of the time, and this all gave to his teaching a life and zest only to be gained by personal investigation. These lectures were, I believe, at the time unpaid, a circumstance which made no difference to a man of his outlook.

Next in histology in 1873—4, though we cut the sections from blocks hardened in bichromate of potash with an ordinary razor, and did not see so much as we were told was there, Dr. Pye-Smith's really wonderful blackboard drawings and his lucid descriptions made up for what we lost in the clumsiness of the preparation. There is in my possession still a section of a liver lobule which pleased him immensely, and I well recall that on that particular day I was the envy of the class, for all were directed to look at my specimen.

But it was when he joined Dr. Pavy in the physiological lectures that we found what a teacher he could be. He took up the course after Christmas, 1873, to a class of a good two hundred men. What a revelation it was to listen to a lecture delivered without a fault in clear, incisive English, unassisted by a note. In these lectures he dealt with the latest advances in the physiology of the nervous system, and I can recall the lecture on hearing, illustrated by his admirable drawings made at considerable labour the day before the lecture. So clearly had he the

picture in his mind that he drew them from an outline he had brought on a mere scrap of paper.

At this time there were but two English books on physiology, Kirke's handbook edited by Morrant Baker, and Carpenter's unwieldy treatise. For the rest we had to read up monographs by Rutherford, Du Bois Raymond, and others, and get what we could out of the recently published laboratory book by Brunton, Klein, and Quain. Gamgee had not yet translated Hermann's, then considered the best, text-book on physiology. To meet our difficulties Dr. Pye-Smith took the M.B. candidates twice a week, giving a free translation of this book while we made notes as fast as possible. Those who were with me will recall with gratitude and pleasure this unique service. He not only translated, but amplified and explained the text, exhibiting an acquaintance with the subject which was, I should think, unsurpassed at that time, in England at any rate. What a splended service it was, and given at no mean sacrifice, for he had his hospital duties as Assistant Physician as well.

In the out-patients and wards he taught us sound medicine and ever kept us on broad lines; declining too intricate discussion, he preferred to give a clear picture unhampered by too much detail. As he had arranged and classified the museum of comparative anatomy, inserting summaries for the guidance of the student, so when he took charge of the Skin Department he set to work to teach on accurate lines, and following the work of Fagge to improve the arrangement of the models illustrating cutaneous affections. He had lived with von Hebra and learnt dermatology from that great authority.

Then as a colleague—Dr. Pye-Smith was always most courteous, accepting the opinion of his surgeon and leaving him to carry out the treatment. I remember being called by him to a girl who had lain comatose for some time and had wasted to a skeleton. Thinking there might be mastoid pressure I was asked to explore the bone. No pus was found, and I naturally proposed to search for cerebral abscess. "Not now, thank you," was his reply, "you have done all I wished, and done it admirably, and I am much obliged to you; if no improvement follows I will ask your help again." A few weeks later the exploration of the brain was called for, again with a negative result. Quite satisfied that the examination had been exhaustive—much more satisfied than the surgeon on this occasion—thus showing his complete confidence, he still gave a favourable prognosis, continued his treatment, and had the satisfaction to witness a complete recovery despite the surgical interference. How delightful to be treated in this way, and by one who had been your master in other subjects. He was satisfied, however imperfect one might have felt one's own efforts had been, and so it always was at the bedside, and, indeed, everywhere, for Dr. Pye-Smith was a true gentleman and never made anyone feel uncomfortable or ashamed.

When the great wave of depression fell upon the School in 1881—2 and the entries fell off, there was much talk of wider advertisement, and a scheme was brought forward in a long speech. Dr. Pye-Smith described all such methods as ephemeral and instanced more than one example, and said he relied upon the efforts of the Staff alone. If all would put their best into their work, improve the pass lists, and the positions taken by our men, recovery would follow; and he was right, for his advice was followed and his prophecy came true, and you may be sure no one worked harder than he did himself.

When the Dental School was proposed, Dr. Pye-Smith opposed the scheme, for he thought he foresaw injury to the Medical side of the School. When adopted, he, with his usual loyalty, did all he could to make the new School successful.

Perhaps we have never had so admirable a Chairman of Committee; always well informed, seldom giving his own opinion except when summing up a debate, he would often, when there were signs of a rising temperature, cool the atmosphere by some pleasantry or apposite remark, putting all at peace. He had rare gifts in this way, besides being even severe when necessary.

Lastly, I must refer to his wide hospitality; not only did he invite his clerks to dinner, but he kept up his friendship with the senior men. We met many of the leading men in science and medicine at his house. I remember on one occasion sitting next to Lauder Brunton, who had the week before examined me in Materia Medica at the M.B., and hoped he would not recognise the candidate who failed to identify a mass of opium. He would show us rare books, in that library in Harley Street, and one was ever increasingly astonished at his knowledge of men and of books. He once told me he endeavoured to read through Homer once in a year, while with Latin he was equally familiar. He spoke both French and German, and, I believe, Italian, and his knowledge of the English Classics was an outstanding feature of his wide reading.

Time would fail to tell of the eloquence of his addresses, of his happy speeches on Prize Day, of the sound advice he gave to students, and of his many acts of kindness.

Dr. Pye-Smith came of a fine old family—no member more remarkable or more honoured than his father, a general practitioner living in Clapton, then inhabited by the great business men of London and by those who had retired. It was there that Hilton ended his days. It is of no small interest to mention that three Guy's physicians were pupils of this admirable practitioner—Habershon, Moxon, and his own son.

CHARTERS J. SYMONDS.

May 30th, 1914.

Gall Stones.

CLINICAL LECTURE BY ARTHUR F. HERTZ, M.D.

GENTLEMEN,—The last few years have seen a complete revolution in our knowledge of gall-stones. Formerly the presence of gall-stones was only recognized in association with an attack of biliary colic. As a result of modern surgery and the frequent operations performed for intractable indigestion, it has become recognized that gall-stones often produce a variety of symptoms in the complete absence of definite attacks of biliary colic. In the last two or three years a further development has occurred in our knowledge of gall-stones as a result of the investigations of Chauffard and his pupils in France in connection with the pathological chemistry of the disease, and the ideas which are still generally accepted as to the origin of gall-stones require very considerable modification in the light of this recent work.

Gall-stones occur much more commonly in women than in men, and among the women about 75 per cent. have had children, and many of them date their symptoms from pregnancy. Out of fifty consecutive cases seen by me in private, thirty-four were women, and of these twenty-six had had children. One lady's symptoms dated from a pregnancy in 1911; she was operated upon, and remained well until January, 1913, when a series of very severe attacks began four days after the birth of another child. Eight stones were removed from her gall-bladder in April, 1913, and she has remained perfectly well ever since. Any explanation of the pathology of gall-stones must explain these ætiological points, and it is in this connection that the commonly recognized theories fall short.

Much stress has been laid upon the association of gall-stones with infections, and particularly typhoid fever, but its importance has been greatly exaggerated. The association in Germany, France and America is largely accidental and due to the frequency of both conditions in these countries, but it is quite unusual in England, where typhoid fever is comparatively rare. I have myself only once observed a case in which a definite connection between gall-stones and typhoid fever appeared to be present, but in two other cases the symptoms began directly after an attack of influenza. In spite of this, most writers on the subject have almost confined their attention to the question of infection, because it has been found at post-mortems and at operations that a gall-bladder containing gall-stones is generally inflamed, and that about 33 per cent. of the gall-stones contain organisms. It has been thought that these organisms and the inflammation of the gall-bladder are essential factors in the production of the stones. The chemical pathology of gall-stones and the possibility that the infection is secondary have been practically neglected.

I wish now to discuss the chemical aspect of the question, because I believe this to be of much greater importance than infection. The majority of gall-stones contain a considerable proportion of cholesterol*; some are practically pure cholesterol. There is always a certain amount of cholesterol in the blood, which is gradually excreted by the cells of the biliary passages and particularly the small canals in the liver. The cholesterol of the bile is kept in an emulsified condition by the cholalic acid radicle of the bile salts. This acid is produced by the liver cells from cholesterol, which is thus not only excreted unchanged, but also in part as cholalic acid. The relation between these two substances is of great importance, because if the proportion of cholesterol is increased there may not be sufficient cholalic acid to hold it in emulsion, and if there is any deficiency of cholalic acid, cholesterol will be precipitated.

The cholesterol in the blood comes from endogenous and exogenous sources. The endogenous cholesterol is produced by the constant activity of the cortex of the suprarenal glands and by the periodic activity of the corpus luteum at each menstrual period. During pregnancy the corpus luteum produces a very large quantity of cholesterol, so that the percentage in the blood gradually increases till it is about 0·25 per cent. during the last two months of pregnancy as compared with the normal of 0·15 per cent. The exogenous cholesterol comes from certain articles of diet; cholesterol is abundantly present in eggs, and to a less extent in cream and in organs, such as liver, kidney, pancreas and brain. All fatty food, even if it contains no cholesterol, also increases the cholesterol in the blood. The importance of the diet is well shown in the comparative immunity of the Japanese to gall-stones, and by the case of a girl with early phthisis, who was treated by over-feeding with eleven eggs a day for six months, at the end of

* Cholesterol is the name recently adopted by physiological chemists to replace the old name of cholesterin.

which she had an acute attack of biliary colic, the excess of exogenous cholesterol having caused a stone to form. In four cases examined by McNee of women who had died from some incidental cause during pregnancy or in labour, the bile was found to contain between 0·6 and 0·7 per cent. of cholesterol in contrast to the normal proportion of 0·15 per cent. This at once suggests that the cholesterolæmia produced by the activity of the corpus luteum during pregnancy causes such an increased excretion of cholesterol in the bile that some of it is likely to precipitate and form the nucleus of gall-stones.

The next point to consider is whether the same factor may not have some connection with cases of gall-stones which are supposed to be purely infective in origin. The unexpected fact then comes to light that the amount of cholesterol in the blood is increased in typhoid fever almost as much as it is in pregnancy; in these cases the extra cholesterol does not come from the corpus luteum, but from the suprarenal gland, which is found in such cases to contain a large excess of cholesterol. Moreover, the bile in fatal cases of typhoid fever, apart from definite disease of the gall-bladder or of the production of actual gall-stones, contains a considerable excess of cholesterol. Thus, even in cases which appear to be obviously a result of infection, this question of excessive cholesterol production is of great importance.

One has still to account for the comparatively rare cases of women who have never been pregnant and have never had typhoid fever, and the somewhat more frequent cases of men who have never had typhoid fever and yet develop gall-stones. Probably there is some chemical factor to account for these cases also. Perhaps, for example, the function of the liver cells, by means of which cholesterol is converted into cholalic acid, is impaired. We know that the liver cells, like those of the kidney and pancreas, may have certain functions impaired whilst others are unaffected. It is conceivable that the power to convert cholesterol into cholalic acid is deficient, so that there will be a tendency for the cholesterol to be precipitated in the bile. In confirmation of this theory, it has been found that in forty-three out of forty-six patients with gall-stones, in many of whom no jaundice was present, the blood and bile contained an excess of cholesterol.

Though excess of cholesterol in the bile appears to be the essential factor in the formation of gall-stones, large stones are rarely produced if the bile flows freely and no infection occurs. But if biliary stasis or infection, either of which by itself would have no effect, occurs in an individual with cholesterolæmia, a stone will probably develop. Biliary stasis is likely to result if deficient exercise is taken or if for any reason partial or intermittent obstruction of the bile-ducts occurs; the latter may be the explanation of the not infrequent association of gall-stones with movable kidney and with general enteroptosis. I have seen two cases of gall-stones, in which the liver had fallen into the right flank.

It has been stated that gall-stones cannot form in aseptic bile, but Chauffard has recently reported a case in which the bile was found to be sterile and the gall-bladder absolutely free from inflammation, although the patient died from shock during an attack of biliary colic; at the autopsy a stone was found impacted in the cystic duct. Although it is thus possible for gall-stones to form in the absence of infection, it has been shown experimentally that their formation from bile containing excess of cholesterol is greatly accelerated if the bile is infected. A very good example of the effect of infection was the case of a woman of twenty-four, who was in Clinical under my care in 1910. Since the birth of her only child three years before she had occasionally suffered from a dull, aching pain in the epigastrium immediately after food, which was occasionally relieved by vomiting, but was never sufficiently troublesome to cause her to seek medical advice. On December 22nd, 1909, she was admitted into the Brook Fever Hospital with typhoid fever on the twelfth day of the disease. Her temperature fell to normal on January 2nd. From January 14th to January 24th she had a relapse, in which the rash returned. On February 1st she complained for the first time of pain in the epigastrium and back, and she vomited. The gall-bladder was found to be enlarged and slightly tender. There was no jaundice or pyrexia. The pain persisted, and attacks of bilious vomiting occurred from time to time. On February 18th the temperature rose to 99·4° F., and the patient was sent to Guy's. On admission her temperature was 99·8° F., and her pulse-rate 120. She complained of pain in the region of the gall-bladder, from which it passed round the right side to the back; she said that it was constantly present, but occasonally became worse. The abdomen was not distended; the upper part of the right rectus muscle was very rigid, but an enlarged and tender gall-bladder could be felt. There was no tenderness elsewhere. Deep respiration

produced pain in the right side of the chest. Suppurative cholecystitis was diagnosed, and Mr. Philip Turner operated the same evening. There was no free fluid in the peritoneal cavity and no peritonitis except in the immediate neighbourhood of the gall-bladder, which was distended, tense and adherent to the surrounding structures. The gall-bladder was opened, and after about four ounces of colourless, clear fluid had escaped, about half-an-ounce of pus was evacuated. About twenty-five faceted gall-stones were then removed from the gall-bladder. They varied in size from an eighth to a quarter of an inch, and consisted of slightly pigmented cholesterol. The clear fluid and the pus both contained a pure culture of bacillus typhosus, which was also isolated from the centre of some of the gall-stones. The gall-bladder was drained, and the patient made an uneventful recovery.

As this was the patient's first attack of typhoid fever and the bacillus typhosus was found in the centre of the gall-stones, it seemed clear that they must have been formed between the onset of the typhoid fever on December 12th and the operation on February 18th, a period of sixty-eight days.

In the light of Chauffard's investigations on cholesterolæmia, however, it now seems possible that the stones were not produced during the attack of typhoid fever, but that their nuclei were laid down three years before whilst the patient was pregnant, as her indigestion dated from that period. The typhoid fever would cause an additional deposit of cholesterol to form owing to the return of cholesterolæmia, and the infection of the gall-bladder would greatly accelerate the development of the stones. The presence of the typhoid bacilli within the stones might be due to migration of the organisms into them, as Gilbert and Fournier have shown that sterilized gall-stones incubated in cultures of bacillus coli are invaded by the bacteria, whilst Chauffard found that gall-stones, only the surfaces of which had been sterilized, could infect a sterile medium in which they were incubated.

By examining sections of gall-stones one can generally get some idea of the history of their formation. Thus the centre of most stones is white and consists of pure cholesterol; only after the stone has reached a certain size is there as a rule any deposit of pigment or lime salts, corresponding to a period of infection. Then there may be a further layer of cholesterol due to a return of cholesterolæmia owing to a second pregnancy; then another stratum of pigment and lime salts may form, and so on. The presence of pigment and lime salts always means infection. A pure cholesterol stone corresponds to a pure oxalic acid or uric acid renal calculus, and the presence of pigment and of lime salts corresponds to that of phosphates in a urinary stone.

I shall not trouble you to-day with an account of an ordinary attack of biliary colic; you will all probably see patients with attacks in the Hospital, and the descriptions in the books are clear enough. But there are two other groups of symptoms, which it is very important you should recognize. One is what we may call gall-stone dyspepsia, and the other consists of abortive attacks of biliary colic.

In gall-stone dyspepsia the patient complains of intractable indigestion. Discomfort or pain comes on at varying periods after meals and is sometimes relieved by vomiting. The patient may obtain partial relief by loosening the clothes, bending forward, or flexing the right thigh on the abdomen. A characteristic feature of the gall-stone dyspepsia is its extreme irregularity. In gastric and duodenal ulcer, as you know, the pain comes on, as a rule, with clock-like regularity a certain time after taking food, the exact time depending upon the situation of the ulcer. In gall-stone dyspepsia, as in appendicular dyspepsia, the indigestion sometimes begins immediately after food, and at the other times in the same patient it may not come on until two or three hours after a meal, or only in the early part of the night, when it is generally less completely relieved by taking more food than is the case with duodenal ulcer. In most cases the patient complains of what he calls flatulence, but on investigating its nature I have found that it is never due to increased fermentation, but to aërophagy caused by the efforts made by the patient to eructate in the hope of getting relief to the discomfort, which he erroneously ascribes to flatulent distension. In the majority of cases of simple dyspepsia, and in all cases of gastric and duodenal ulcer, more or less relief is temporarily obtained by means of alkalies, but they give no relief at all when the dyspepsia is due to gall-stones.

Many patients who suffer from gall-stone dyspepsia, and a few who have no such symptoms, complain of short attacks of severe pain, which may occur at any time of the day or night without any obvious cause, such as an indiscretion in diet, although occasionally an attack is the direct sequel of a long railway journey, a drive in a motor-car on a bad road

or on a motor omnibus, or of violent exercise. A patient of mine had a severe attack of biliary colic on two occasions immediately after spending two whole days in the train while travelling in America. Attacks may occur daily or at long intervals, or there may be a series close together followed by a long spell of freedom. The patient very often shivers during an attack, although his temperature never rises greatly and often does not rise at all. Sometimes the shivering is accompanied by a sensation of "goose-skin," particularly in the epigastrium and right side of the upper part of the abdomen. When the pain is acute it is impossible to take a deep breath, the attempt producing a "catch" in the right side of the chest, which is very similar to what is felt in pleurisy.

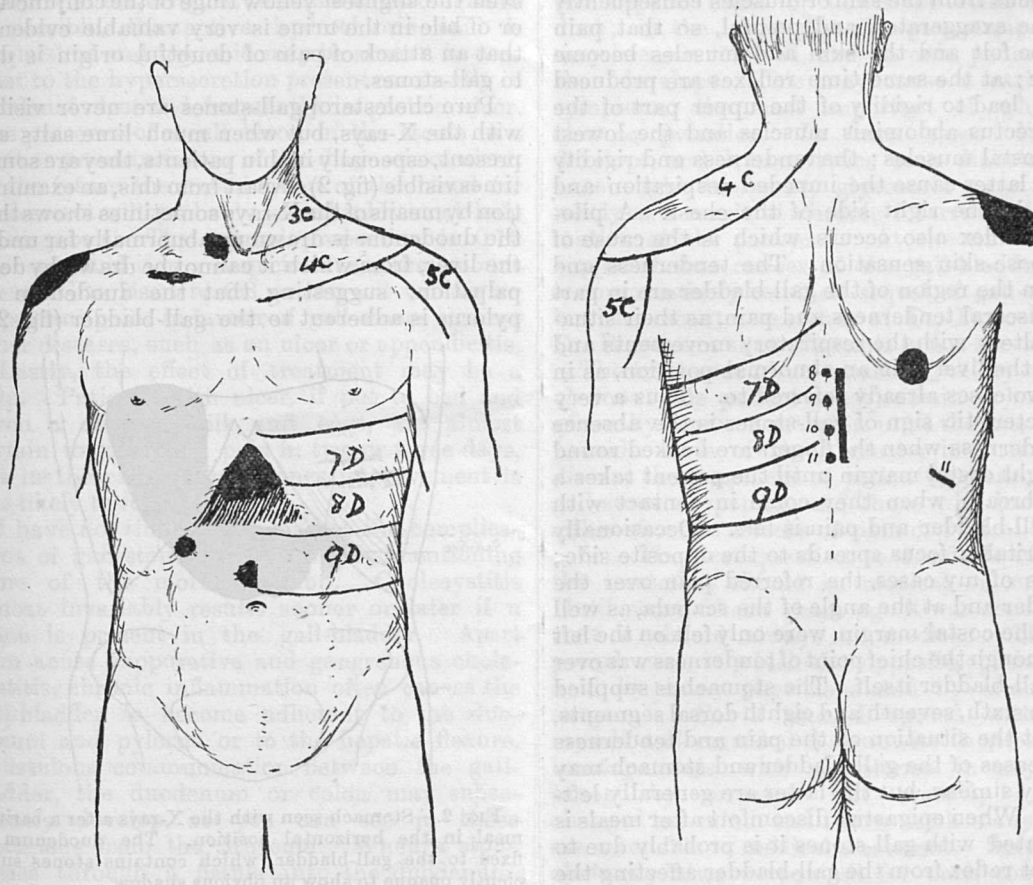


FIG. 1.—Areas of pain and tenderness which may be associated with gall-stones, and the areas supplied by the 3rd, 4th, and 5th cervical and 7th, 8th, and 9th dorsal spinal segments.

Patients with gall-stones suffer pain or discomfort and tenderness in several situations (fig. 1). The discomfort after meals is generally in the epigastrium and less frequently just above and to the right of the umbilicus. The attacks of colic, whether abortive or fully developed, often begin in the same situation. In most cases they spread round the right side of the chest to the back, the point of greatest pain and tenderness being over the gall-bladder itself. The chief pain behind is generally at the angle of the right scapula. After the attack has passed, a dull ache often remains for a long period in the same situations and also occasionally over the top of the right shoulder, and in rare instances at the insertion of the right sterno-mastoid muscle and under the right clavicle. At the same time there is often some tenderness over the eighth, ninth and tenth dorsal spines and over the muscles to their immediate right. The end of the eleventh rib may be tender. The diagram shows that all the tender and painful areas are in the distri-

bution of the seventh, eighth and ninth dorsal, and the third, fourth and fifth cervical spinal segments. This is due to the fact that the gall-bladder and bile-ducts are supplied by nerve fibres coming from these spinal segments, those from the cervical region being conveyed in the phrenic nerve. The afferent impulses from the distended and consequently painful gall-bladder or bile-ducts produce an irritable focus in the spinal cord; normal sensory impulses reaching this focus from the skin or muscles consequently become exaggerated and painful, so that pain may be felt and the skin and muscles become tender; at the same time reflexes are produced which lead to rigidity of the upper part of the right rectus abdominis muscles and the lowest intercostal muscles; the tenderness and rigidity of the latter cause the impeded respiration and stitch in the right side of the chest. A pilomotor reflex also occurs, which is the cause of the goose-skin sensation. The tenderness and pain in the region of the gall-bladder are in part true visceral tenderness and pain, as their situation alters with the respiratory movements and when the liver is in an abnormal position, as in the two cases already referred to. Thus a very characteristic sign of gall-stones is the absence of tenderness when the fingers are hooked round the right costal margin until the patient takes a deep breath, when they come in contact with the gall-bladder and pain is felt. Occasionally the irritable focus spreads to the opposite side; in one of my cases the referred pain over the shoulder and at the angle of the scapula, as well as at the costal margin, were only felt on the left side, though the chief point of tenderness was over the gall-bladder itself. The stomach is supplied by the sixth, seventh and eighth dorsal segments, so that the situation of the pain and tenderness in diseases of the gall-bladder and stomach may be very similar, but the latter are generally left-sided. When epigastric discomfort after meals is associated with gall-stones it is probably due to a direct reflex from the gall-bladder affecting the movements and secretion of the stomach.

It is generally impossible to palpate the gall-bladder during an attack of acute pain owing to the rigidity of the abdominal muscles, but when the attack passes off the tenderness often becomes localized to the gall-bladder itself. In some early cases it is found to be enlarged owing to distension with clear fluid, especially if the stone is impacted in the cyst duct. But when chronic inflammation has occurred in a patient who has suffered for many years from gall-stones, the gall-bladder contracts and is very rarely palpable. Even if a gall-stone passes into the common bile duct, the gall-bladder does not become enlarged; this is the basis of "Courvoisier's law," according to which a large gall-bladder in a case of chronic jaundice indicates a growth of the head of the pancreas or of the common bile duct, whilst an impalpable gall-bladder suggests the presence of an impacted gall-stone.

It is important to remember that only a small proportion of individuals with gall-stones ever suffer from jaundice, though the presence of even the slightest yellow tinge of the conjunctiva or of bile in the urine is very valuable evidence that an attack of pain of doubtful origin is due to gall-stones.

Pure cholesterol gall-stones are never visible with the X-rays, but when much lime salts are present, especially in thin patients, they are sometimes visible (fig. 2). Apart from this, an examination by means of the X-rays sometimes shows that the duodenum is drawn up abnormally far under the liver, from which it cannot be drawn by deep palpation, suggesting that the duodenum or pylorus is adherent to the gall-bladder (fig. 2);

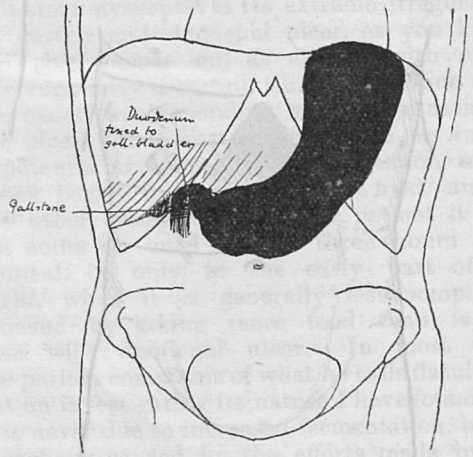


FIG. 2.—Stomach seen with the X-rays after a barium meal in the horizontal position. The duodenum is fixed to the gall-bladder, which contains stones sufficiently opaque to show an obvious shadow.

this may, of course, be due equally well to an ulcer as to gall-bladder disease. Occasionally a spasm is visible in the centre of the stomach; but this is of no great value in diagnosis, as a reflex gastric spasm occurs also in appendicitis and with ulcers of the lesser curvature. The X-rays, moreover, often furnish definite evidence of the presence of a gastric or duodenal ulcer, but gall-stones may, of course, be present at the same time.

In many cases of gall-stones there is never any pyrexia, but in a doubtful case it is advisable to

have the temperature taken every half-hour during the attacks of severe pain, as the temperature often rises slightly. Even a slight rise is very important, as it proves that some organic condition is present, and it also excludes the possibility of uncomplicated gastric or duodenal ulcer.

Gastric analysis sometimes helps the diagnosis; in very early cases the amount of hydrochloric acid in the gastric juice is increased, but in the vast majority, at the time when diagnosis is possible, the active hydrochloric acid is diminished and free acid may be absent, in contrast to the hypersecretion present constantly in duodenal ulcer and frequently in gastric ulcer. The presence of occult blood in the stools is a further point in favour of the diagnosis of ulcer. In the future the examination of the blood for cholesterol will probably afford additional help in diagnosis. The normal proportion is 0·15 per cent., and if in a suspicious case the amount present has risen to 0·3 or more it will be an important point in favour of gall-stones against other diseases, such as an ulcer or appendicitis.

Lastly, the effect of treatment may be a help. Patients with ulcer, if put to bed and given a diet of milk and eggs, are almost certain to lose their pain in two or three days, but in the case of gall-stones improvement is less likely to follow.

I have not time now to discuss the complications of gall-stones beyond briefly mentioning some of the more common. Cholecystitis almost invariably results sooner or later if a stone is present in the gall-bladder. Apart from acute suppurative and gangrenous cholecystitis, chronic inflammation often causes the gall-bladder to become adherent to the duodenum and pylorus or to the hepatic flexure. A fistulous communication between the gall-bladder, the duodenum or colon may subsequently develop, as you can see in these specimens from the Museum. When a stone passes through a fistula into the duodenum, intestinal obstruction may occur, as in a case which was under my care in Clinical in 1909. A stout woman of 51 was admitted with acute intestinal obstruction, which had already been present several days. She had had previous attacks of abdominal pain, and the present attack was preceded by severe pain under the right costal cartilages. Her abdomen was tender and slightly distended but not rigid, and fæces were found in the rectum. Both Mr. Fagge and I thought that the obstruction was most probably due to gall-stones from the history and appearance of the patient. Mr. Fagge operated at once. The small intestine was dilated and the colon collapsed. As soon as he put his hand into the pelvis he felt two stones, which were freely movable in the ileum, and he subsequently found a third, which was impacted two inches above the ileo-cæcal sphincter. The stones were removed, but the patient had had obstruction for so long that it was not surprising that she died four hours later.

In some cases inflammation may spread up the hepatic ducts or down the common bile duct; in the latter case the pancreatic ducts may become infected, and chronic pancreatitis then develops. This may cause a variety of symptoms, the most important of which is chronic jaundice. In rare cases diabetes develops, and I have twice seen diabetes and once slight temporary glycosuria occur apparently as a result of chronic interstitial inflammation of the pancreas. At one time it was supposed that cancer of the gall-bladder was a comparatively common sequel of gall-stones, but the recent researches of Dr. Fawcett and Dr. Rippmann show that this is not the case.

The treatment of an attack of biliary colic is obvious; the patient must remain in bed, and generally requires morphia until the attack has passed. It is of much greater importance to discuss the treatment of patients suffering from gall-stone dyspepsia, and those who have had either abortive attacks of pain or typical biliary colic. The first question to decide is whether the treatment should be medical or surgical. Until some fifteen years ago it was considered that it should always be medical. Then a period came in which the opposite opinion was held by many physicians and by almost all surgeons. For a time I agreed with this myself, and regarded it as unwise to attempt to treat patients with gall-stones in any way except by surgery. But recently I have changed my mind, and I now think many cases are amenable to medical treatment. Surgery is obviously always required for such complications as empyema of the gall-bladder, suppurative cholecystitis, and gall-stones impacted in the common duct or producing intestinal obstruction. One ought never to wait for the gall-stones to produce severe infective symptoms, even a slight rise of temperature of more than a few days' duration being a sufficient indication for operation.

I have now seen a number of patients with gall-stones, who for various reasons were unwilling to be operated upon and asked to be allowed first of all to give medical treatment a trial. Rather unwillingly I suggested treat-

ment with diet and drugs. In several cases the treatment has been more successful than I had anticipated, many of the patients having had no return of symptoms for a considerable period. I think, therefore, that it is worth while advising medical treatment first in every case unless there is some indication present which makes it obvious that an operation will ultimately be required. The object of medical treatment is primarily to cure the cholecystitis, which is generally the chief cause of the symptoms in cases of gall-stones. At the same time an effort must be made to reduce the percentage of cholesterol in the bile, as by this means the further growth of the stones may be arrested and the formation of new ones prevented. It should, moreover, be remembered that pure cholesterol stones are dissolved by the bile when introduced into the sterile gall-bladder of a dog, so that it is quite possible for a true cure to result if the bile is rendered sterile, as small cholesterol stones might then be dissolved.

An important part of the medical treatment of gall-stones is the diet, and it is in this that the new observations I have spoken about are of the greatest help. You must order a diet which will prevent as far as possible the introduction of exogenous cholesterol. So you will allow the patients to have no eggs at all, not even when cooked with food. Liver, kidneys, sweetbread and brain must also be rigorously excluded. The amount of fatty food should be reduced as much as possible by avoiding cream, the fat of meat, and suet, and taking the smallest possible quantity of butter. With such a diet it is unlikely that a cholesterol stone will get much larger in the absence of pregnancy or typhoid fever. Gall-stones are so very common among women who have born children, even if symptoms do not develop till many years later, that it is a question whether it would not be wise to give the necessary additional food to pregnant women as much as possible in the form of carbohydrates instead of fats and to exclude eggs completely from their diet.

As the gall-bladder contracts whenever food is taken, biliary stagnation can be diminished by giving small intermediate feeds in addition to the three chief meals, the size of which are reduced by the exclusion of eggs and the other prohibited articles of diet.

It is important to avoid long railway journeys and jolting in vehicles as much as possible and to take no violent exercise, though moderate exercise is very beneficial. When there is any tendency to enteroptosis an abdominal support should be worn.

With regard to medicinal treatment, certain drugs, especially salicylic preparations and urotropine, are of great value. Salicylic acid acts as an analgesic; it is a chologogue and a biliary antiseptic, as it is excreted in part in the bile; although the bile becomes more watery, the quantity formed is so greatly increased that the total amount of cholesterol is increased and the quantity of cholesterol in the blood is thereby reduced. I suggest giving five grains of acetyl-salicylic acid (aspirin) six times a day for several months after the three chief meals and the three intermediate ones; the frequent administration is advisable because it is rapidly excreted, the largest proportion being present in the bile after two hours. So long as there is any evidence of cholecystitis, as much urotropine as the patient can take should also be given, as it is the best of all biliary antiseptics. In my experience the majority of patients cannot take more than ten grains three times a day without being troubled with irritation of the bladder, which is shown by frequency of micturition and occasional hæmaturia, but sometimes as much as a drachm can be taken in the day. The larger dose is a great advantage, as the quantity of formalin excreted by the bile is then greater. The routine administration of urotropine in typhoid fever is important as a prophylactic of infection of the biliary as well as of the urinary tracts.

At one time olive oil was a great deal given for gall-stones with the object of dissolving the stones, for cholesterol is soluble in oil; but it was never explained how the oil was to reach the gall-bladder. The chief evidence of its value was the passage in the fæces of rounded waxy masses, which were supposed to be the gall-stones. These are now known to be formed of calcium soap produced from the oil and to have no connection with gall-stones at all. In early cases, however, when excess of hydrochloric acid is secreted by the stomach, olive oil may be given before meals to thin patients, as in addition to being a valuable food it reduces the gastric secretion, the excess of which may be one factor in producing the gastric discomfort. When there is much pain, belladonna should also be given as an antispasmodic. The bowels should be kept regular by saline aperients or liquid paraffin.

Benefit is often derived from a visit to some spa, such as Vichy or Karlsbad, especially now that milder treatment has been adopted, the object of which is not to expel stones, but to improve the patient's general condition, to diminish any gastritis which may be present, and to disinfect the bile passages.

It has, moreover, recently been proved that the consumption of the warm alkaline waters of Vichy greatly reduces the amount of cholesterol in the blood. Vichy is probably best for thin and Karlsbad for stout patients.

Now just a few words with regard to operation. When medical treatment has failed and the patient continues to have indigestion or frequent attacks, whether abortive or severe, an operation should be advised. It should be remembered that even in uncomplicated cases the operation is not without danger. Two of my patients died within forty-eight hours for no obvious reason, as there was no trace of any infection present. One very important point I wish to impress upon you is that if the surgeon examines the gall-bladder and bile ducts and finds no stone, so long as no other obvious cause of the symptoms, such as a diseased appendix or a duodenal ulcer is discovered, ask him to open the gall-bladder all the same, or if it looks diseased have it removed, because it is not at all rare for typical symptoms of gall-stones to result from minute deposits of cholesterol in the walls of the gall-bladder; in such cases a cure only results if the gall-bladder is removed. Two years ago I saw a man of twenty-six with obvious symptoms of gall-stones. He was anxious to live in Madagascar, so I advised operation without trying medical treatment. He went to a surgeon of another hospital, who opened the gall-bladder and drained it, although nothing more than minute deposits of cholesterol were found. All the symptoms quickly returned, so I asked Sir Alfred Fripp to remove the gall-bladder. This was done in March of this year and deposits of cholesterol were found in its walls. Since then he has been completely free from symptoms and is now leaving England for Madagascar. Quite apart from this, you must remember that a chronically inflamed gall-bladder, from which the stones have escaped, may give rise to symptoms, and in such cases it is advisable to perform a cholecystectomy.

A patient who has had gall-stones removed by operation should be careful with his diet and perhaps from time to time take some salicylate and urotropine in order to prevent their re-formation. This would be particularly important in the case of a woman becoming pregnant or in any patient developing typhoid fever. Apart from true recurrences, it is not uncommon for the symptoms to return within a few months of the operation. When this occurs, it is probable that all the stones were not removed; when large numbers are present it is not at all easy to be certain that one or more may not have been left behind, particularly in the hepatic duct. I have seen this happen on four occasions. The patients were regarded as neurotic, but from my experience of these cases I should certainly advise a patient to undergo a second operation, if the symptoms returned with their original severity within a few months of the first operation.

The Need for Organization in the Nursing Profession.

BY MISS MARGARET ATKEY.

(*Continued from page 199.*)

This want of co-operation seems trivial in individual cases, but when we realise that it is going on in every town and village in the kingdom, surely it must represent in the aggregate an enormous waste of energy, of over-lapping and loss of public confidence. For it does not increase the esteem in which the district nurse is held if, when she brings a patient to the hospital he sees the Sister of the ward treat her with scant courtesy. Later on, when she may be nursing some other member of his family it is more than likely that her advice will be disregarded because "Sister Blank didn't think much of the likes of her." It is bad for the hospital, too, for one can hardly expect that district nurse to encourage a gift towards the hospital on the part of the patient, however well-to-do he may be. In other cases patients are nursed on the district who would be better in hospital, and many others continue to occupy much-needed beds in the hospital who could easily be nursed at home, because of the lack of co-operation between these two branches of the profession.

It is all so bad for us; and I think the loss to the nursing profession and to the community at large by these narrow and short-sighted methods can hardly be exaggerated.

I think a good deal might be done to remedy this state of affairs if all the nurses in a given area could be brought into contact with one another. They could learn so much by getting to know each other and something of other methods and by realising that they are not alone in their work. If there were in every town a Nurses' Club where afternoon tea could be obtained very cheaply, where a game of billiards could be enjoyed, books of reference consulted, papers and magazines seen, and lectures given on social and nursing subjects, the result would be that new ideas would come in to blow away the cobwebs of prejudice and jealousy, fresh points of view would emerge, the older members would be prevented from getting into ruts, and a happy social life take the place of the present

dreary monotony which characterises off-duty hours. New nurses might then leave their training school, or a previous post, with an introduction to the club secretary, and find help and advice in those difficult first few months before they find their way about, even if it were only in trivial matters, such as the discovery of a satisfactory laundress, or short cuts about the town. Matrons of hospitals could do much in bringing the nurses together, by getting speakers and helping at meetings, or by inviting the club members to a musical evening or garden party at the hospital, but every nurse would have to do her share towards the success of the venture, and would thereby gain much valuable experience in administration and business methods.

So much for the nurse as an individual. Now let us consider the nursing profession *en masse*. As a profession we can hardly be said to exist. At the end of 50 years we find ourselves a great helpless, voiceless mass of women, quite at the mercy of our enemies. Bills are brought into Parliament affecting our very existence, and the mass of the profession know nothing of the questions under discussion. We are unable to make our voice heard on any matter concerning our own welfare or that of the sick throughout our land. We are quite unable to govern our own affairs, much less to give a lead to those of our legislators whose duty it is to decide on such questions as the terms upon which we should be insured, the desirability or otherwise of State Registration, or whether policeman, doctor, or nurse be best fitted to inspect our Nursing Homes.

The nurse as an individual may not be so evolved as we should wish, but *qua* individual she is a force to be reckoned with; collectively we simply do not count. Except for a few attempts here and there at union and expression, we find an inarticulate mass of women, who yet, could they unite, are numerous enough to make themselves felt in many departments of public life, strong enough to classify its training schools, to insist on thorough and efficient training for pupil nurses, to defend its weaker members, and rich enough to provide for our own needs.

Yet we do none of these things! We are, in fact, a body of women possessing skilled knowledge and active brains, but yet useless in all national issues and unable to protect even our own uniform. Here and there, it is true, tiny glimmers of a sense of solidarity may be discerned. Our nursing papers express something of the unity which is so much needed. During the last thirteen years efforts have been made by a few far-seeing members of the profession to organise in the hope of keeping alive the idealism which has stood for all that is best in our work, and of both governing our own affairs and upholding our prestige in our relations with the State. But this valuable work is terribly handicapped by the apathy and indifference of the great majority of nurses throughout the country. The nurse of the future *must* organise to transform our great profession from its present position of helplessness into a forceful, articulate community capable of making itself heard in all matters affecting the sick and needy, for surely no body of men or women have a better right both to an opinion and a courteous hearing!

I have placed the local needs for organisation first, because I believe that they are, if possible, the more urgently needed, but we as a profession must have a representative body, not only to interpret our needs to the Government and influence legislation, but to control our own affairs. There are many ways in which the training of nurses could be rendered more efficient and the interests of the probationer safeguarded if a central body who were quite independent of the local committees who now legislate for the needs of the nurses under their charge were strong enough to uphold the Matron in her desire to provide her probationers with the education and opportunities for which she now so often struggles in vain.

The time has come when all nurses who really care for nursing ideals, and aim at reducing the sum of human suffering, must rouse themselves and throw in their lot with this movement. Organisation is inevitable, it cannot be long delayed, and our very best are needed as leaders. I say this because, though, as a great voiceless mass of women, we are comparatively powerless for good or evil, as an organised community we might either become a great power for the advancement of human progress, or if we let go the spirit which actuated the founders of the profession and allow ourselves to catch the spirit of strikes and struggles for selfish ends, a great calamity will have befallen the human race.

In all great movements there are dangers to be guarded against and difficulties to be solved. The danger of organising is, I think, that the struggle for professional advancement may be placed before the interests of the sick. If our best and most single-minded nurses continue to allow themselves to become so absorbed in their own individual work that they cannot realise their responsibility in this matter, other nurses who care little for such ideals will and must organise, and it will be from a lower standpoint.

Should this happen the whole profession will fall from the place of honour it has held in the past and is struggling to maintain. I cannot too strongly urge all nurses who care for the best interests of the nursing profession to throw in their lot with any organisation which has a democratic basis and the aims of which are wide enough to include not only professional advancement, but the welfare of humanity, and to help in any way in their power a movement which will, I believe, carry our great profession on to hitherto untrodden spheres of public service where its ideals and standards will be a purifying influence in the national life of the future.

A Holiday in British Central Africa.

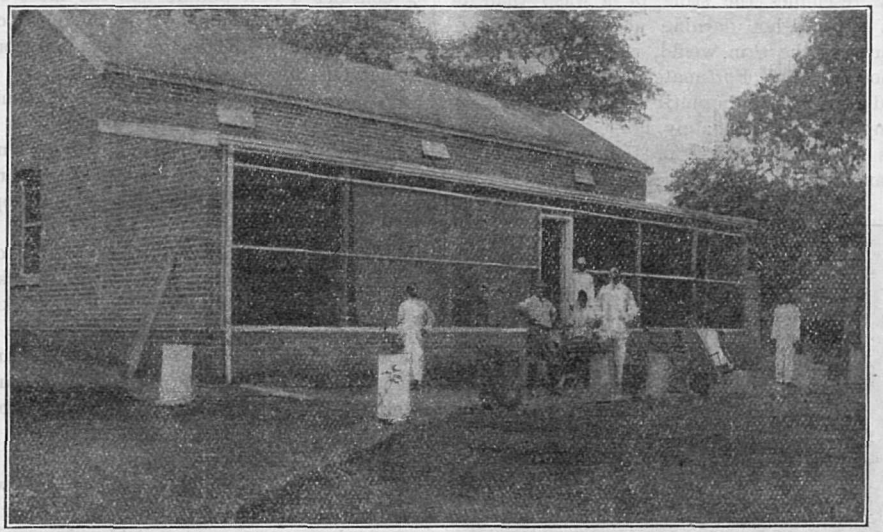
IN 1908 I contributed an article to the GAZETTE on a photographic and big game expedition into N.W. Rhodesia, on which trip I was accompanied by Redpath, an old Guy's dental student. On that trip we had exciting experiences with lions, elephants, and hippos, not to mention a big variety of Central African antelopes. On the expedition in 1913 the dangerous game I personally encountered were elephant, rhino, buffalo, and leopard, whereas my friend Halse, the son of a well-known African pioneer and farmer, had the good fortune to secure a lioness. The particular object of this expedition, from my point of view, was to secure telephoto pictures of Central African game in their natural state and to obtain specimens of black lechwe, a rare antelope to be found only on the south-east shores of Lake Bangweolo, which lies slightly north of Chitombo, where Dr. Livingstone died in 1873.

Last August we entrained to Bwana M'Kubwa, and, in company with 20 carriers, whom we obtained from a trader at that place, trekked to N'dola, which is the most northerly station on the Cape-to-Cairo railway before it enters the Belgian Congo. Here we were most hospitably entertained by Dr. P. H. Ward, an old Guy's man of the late 'eighties and early 'nineties, who will be remembered by many readers as one of Guy's most lengthy as well as one of her most genial students of those years. Mrs. Ward, daughter of Dr. Cock of Peckham, was in England at the time, but I now learn from Ward that his lady has returned to N'dola, bringing with her three small British citizens (she left a few months previously with but two).

A day's march to Sakania in the Congo, and from thence through Belgian territory for sixty miles to the Luapula River, brought us to the borders of British Central Africa. Most of our hunting was done between this river and Lake Bangweolo (a distance of perhaps 150 miles); along the west coast of the lake, and south of the lake to the Luambwa River. In a *dambo* (an open grassy stretch between wood), whilst passing through the above-mentioned strip of Belgian territory, we were both terribly bitten by tsetse flies, although there was present here a remarkably small quantity of big game, and no pachyderms or buffalo.

I would like here to raise my voice against the threatening attitude of several writers in the medical periodicals recently in favour of the total extermination of big game in certain parts for the very questionable purpose of thereby exterminating glossina palpalis and glossina morsitans, the acknowledged infecting agents of human beings with sleeping-sickness. One might advance many practical reasons for not attempting the extermination advocated, but the following appear to me to carry great weight:—

a. It often obtains, as above stated, that in the absence of a plentiful game supply, glossina palpalis and glossina morsitans are very prevalent. There is obviously some localising influence on the fly distribution, independent of big game, since on this expedition both Halse and I noticed that on one side of the Luambwa River, where only a few waterbuck and



DR. WARD OUTSIDE HIS HOUSE AT N'DOLO.

pookoo were to be found, it was almost impossible to hunt owing to the teeming thousands of fly, whilst on the other bank of the river, little more than a stone's throw off, where game was very plentiful, there was no fly. We noticed a similar state of affairs on one or two other occasions.

b. It has by no means been satisfactorily proved that big game animals are the only carriers of trypanosomiasis, if I am to be guided by reports published by workers on the disease, and personally I am of the opinion that the smaller mammals, and even birds, may be likewise aggressors.

c. An attempt to exterminate game in any but very small districts must be attended by failure. I speak as one competent to give an opinion, having studied the habits of African game for many years.

You who have not experienced the sting of a tsetse fly will be interested to know that the sensation experienced from the thrust of its dagger-like proboscis more nearly resembles the sting of a wasp than of a mosquito. A red-hot darning needle thrust some half inch through the skin would, methinks, liken the sensation most nearly. Fortunately he retires to bed at dusk and sleeps soundly until the sun is well up next morning, but unfortunately he leaves the hours of darkness to another devil in the person of the ubiquitous anophilis.

BULL BUFFALO.

Shortly after crossing the Luapula, Halse was laid up with a troublesome bronchial attack, which necessitated halting for a few days, and after this carrying the sick man on a *machila* for three more days owing to his extreme weakness. But to return to ourselves as the hunters and not as the quarry.

Buffalo.—In the early part of the expedition I took up the spoor of a big herd of buffalo, and after following it for three hours, came upon the animals, about 50 in number, reclining amongst scattered trees some two miles away from their grazing ground in the reedy swamp of a small river. The sight as I watched it from the top of a big antheap was indeed grand, and I regret ambition to secure the head of an exceptionally fine bull that stood facing me, and suspecting danger, caused me temporarily to overlook the fact that photography was the first consideration. I bagged the bull, but the stampede which followed the shot whilst the animals disappeared in a cloud of dust gave no opportunity for a permanent photographic record. No finer opportunity will ever be offered a hunter to secure an excellent photograph of a big herd of these powerful and dangerous beasts than I had on this occasion. An accompanying photograph shows the dead beast, the head of which now graces my collection. Later I secured a young bull from this same herd, and a fortnight later wounded a big bull, which discretion, in contradistinction to valour, caused me to abandon, since the animal retreated into high grass and was apparently in a dangerous frame of mind. Of all Africa's dangerous game I consider a bull buffalo has the most terrifying and formidable appearance, although, unless conditions are very adverse to the hunter, I do not consider him so dangerous an opponent as lion, leopard, or elephant.

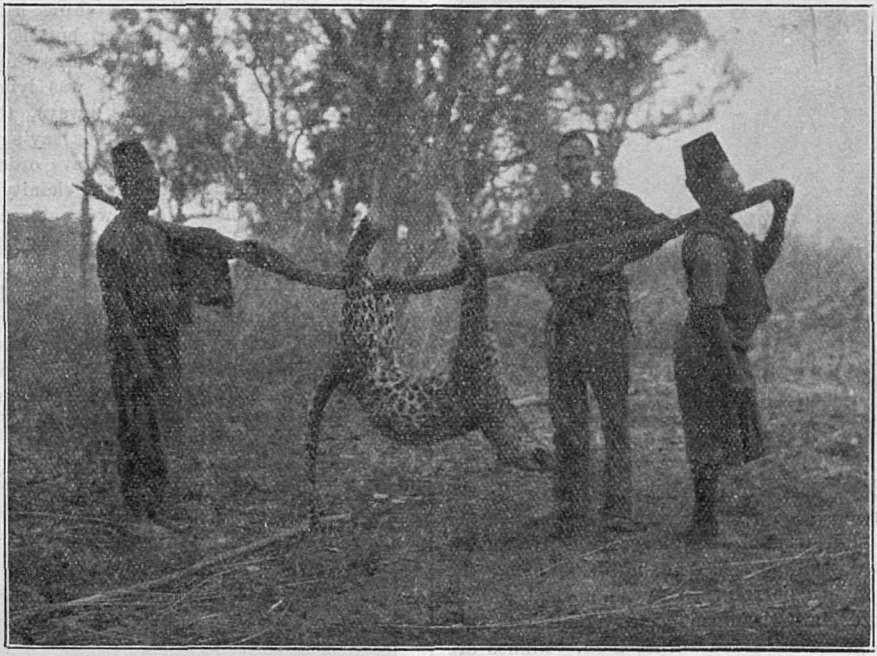
Leopard.—One evening on the Luambwa River a boy came excitedly into camp saying a herd of roan antelope was quite close and begging me to go out and shoot one. Although we were not really in need of meat, I thought this an excellent opportunity to leave an animal out for approaching in the early morning with hopes of securing one of the larger carnivora. Although it was nearly dark, by a lucky shot with a bullet in the forehead, I killed a young roan and left it where it fell on the edge of the wood. Before sun-up the next morning, with the stealth of a jackall I approached the carcass and was delighted to see, whilst yet a long way off, an animal, which I recognised with the glasses to be a leopard, feeding on the dead beast. In the wood it was possible to approach within 80 yards, well concealed by the side of a high antheap in long grass. Presently he gave me a broadside view, and a ·303 soft-nosed bullet, which tore a big hole through the chest just behind the heart, gave an unkind shock to the beautiful spotted cat. He sprang to one side of the carcass and lay down almost concealed from view in some long grass. Two more shots at the almost hidden target only grazed him. Whilst waiting to get a clear view of the beast, which I could see by the movements of his head was licking his wounded side, he caught sight of me, and without more ado bore down for me at a huge scrambling gallop accompanied by savage grunts. I jumped back to a small tree for additional protection and stood at the present, but fortunately for me the wound was of so severe a character that he could not maintain his charge, and he fell down exhausted twenty yards from where I stood. Cautiously retiring, I joined the boys some 200 yards from the wounded animal, intending to return and give the coup-de-grace in an hour or

two's time when he had had time to become "stiff." From an antheap in the distance I could see him kicking up the dust and was in hopes it was his last kick, but No!

On returning to camp to have a snack of breakfast I found Halse had not gone out, so after a meal of Kaffir corn porridge and fried pookoo steak (flour for bread making was exhausted some days) and a pipe, we set out together for the finale. Approaching carefully the spot at which I had left the leopard we found he had decamped, but the spooring boy soon picked up the blood spoor entering the thick wood. After following this for 100 yards a suppressed growl in the distance caused the boys to turn tail and retreat behind the guns, leaving the white men to continue the spooring. There was much thick undergrowth and approaching a wounded animal was particularly dangerous, but the skin was too valuable a trophy to be left on the African veldt. We soon came on the spot where he had been lying, as evidenced by a pool of blood under a low thick-leafed tree. An easily climbed tree on the line of spoor was quickly scaled, and after a lengthy survey of the surrounding bush I spotted the beast in a crouching attitude watching me and preparing to spring just 18 yards from the foot of the tree. A word of warning to Halse in a whisper; he handed up the ·303, and a soft-nosed bullet truly placed gave rise to a series of unearthly growls. But the wounds were too severe and a charge was out of the question. A final shot gave the quietus. A fine male leopard measuring 6 ft. 10 in. from tip to tip.

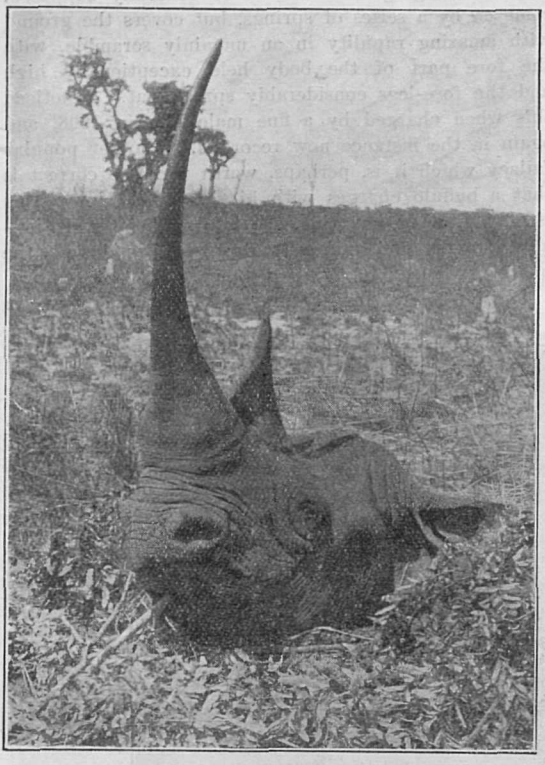
It is interesting here to note that either a lion or leopard charging does not, as is generally supposed, come on by a series of springs, but covers the ground with amazing rapidity in an ungainly scramble, with the fore part of the body held exceptionally high and the fore-legs considerably spread out. I noticed this when charged by a fine male lion in 1908, and again in the instance now recorded. Another popular fallacy which it is, perhaps, worth while to correct is that a buffalo charges with his head held low. This is not so; when charging, the head is held exceptionally straight out, and only dropped just before the quarry is within striking distance.

Rhino.—Early one morning when walking just on the edge of a wood bordering a *dambo* some 400 yds. across, I saw a troop of zebras and was approaching a short distance into the open to obtain a telephoto picture when, glancing down the *dambo*, I saw some 700 yards away an animal which with the glasses I recognised as a fine maned lion, slowly sauntering along towards the wood which he would have entered some 500 yards from where I stood. The zebras were quickly forgotten, and taking the ·303 I started at a trot to attempt to cut off the lion before he entered the wood. I had only run 100 yards when out of the wood walked a fine male rhino, crossing my path and not 30 yards away. What to do was quickly decided since the animal was a magnificent one and a trophy



LEOPARD.

not to be despised, but a difficulty stood in the way. I had but the ·303 sporting rifle and only soft-nosed bullets absolutely useless against the pachyderms.



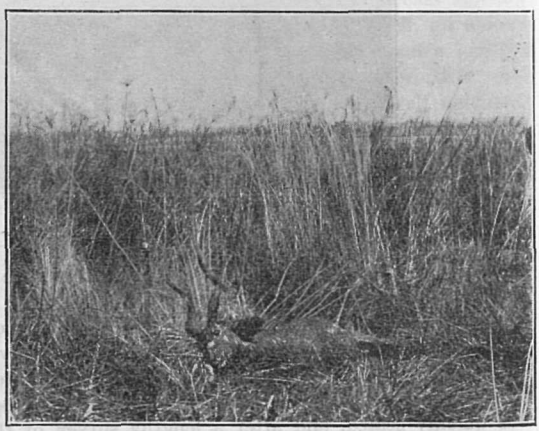
Rhinoceros.

The spare boys were some distance behind with the heavy ·600 express. Fortunately the wind was in my favour, and I instructed the gun carrier to retreat into the wood, run post haste, and bring along the heavy rifle. When he returned the rhino had walked some 300 yards into the open country, and I had to stalk him in grass but a few inches high. Rhinos are particularly short-sighted, and I got to within 100 yards by taking advantage of this weakness and only moving when the beast's head was turned away. Click! Miss fire! The rhinoceros turns in my direction, having caught the sound. False alarm, he meditates, and continues to browse. The trigger is pressed a second time, and the bullet sets home near the heart. A third shot—miss fire! and he comes in my direction like a steam engine, but not being quite satisfied of my whereabouts he rushed backwards and forwards for a couple of minutes and then slowly collapsed on his knees, and so passed away in the same attitude as is most common in these animals at the death. An accompanying photograph gives a good idea of his magnificent horn, 33½ inches long, an excellent specimen at the present day.

The reason for the miss-fire was discovered later, and since neither the maker nor I accept responsibility, the responsibility will most likely not be discovered. After killing the rhino I spent some hours trying to get on the spoor of the old lion, but the ground was dry and left no sufficient impression; but two days later I killed a fine bull eland which had been severely mauled by this self-same animal.

Halse had an interesting experience with a male lion. He was following a lion spoor early one morning when he came to a big hole at which the animal had been scratching, as evidenced by sand scattered all around bearing the recent spoor of the lion and portions of the roots of a tree which had been dug out. Whilst inspecting the hole out dashed a big wart-hog almost in his face and made off for dear life at anything up to 30 miles an hour. Halse now caught sight of the lion watching him on a slight woody rise some 150 yards off, but he was unable to get a shot before *felis leo* decamped for good.

Hyænas.—One night when I was lying ill with an intestinal attack (Halse was away), the cook came running excitedly into my zareba saying a big animal was walking about outside. I gave orders to burn all the long grass in the immediate vicinity of our camp, and soon the whole place was ablaze. Suspecting hyænas I poisoned some meat with strychnine and told the cook to place it down a small sluit below our camp. The meat was taken during the night, and next morning, feeling somewhat better, I sauntered out with the camera to the flat 300 yards away. From the top of an antheap I was just preparing to take a telephoto of some pookoo when, glancing behind me, there stood a big hyæna at 60 yards watching my



Sitatunga.

movements. It only meant swinging the camera round to take a photo of this ungentlemanly-looking beast. The picture turned out fairly good, and would have been excellent had not the early morning sun been in the face of the camera. I then shot the hyæna,

which turned out to be a big male returning to look for his lady that I found later lying nearer camp dead from strychnine.

We both had excellent sport with Africa's most water-loving antelope, the sitatunga. These animals are always to be found in swampy ground and may, where plentiful, be seen towards evening and in the early morning feeding in water nearly up to their bellies. Hunting this antelope necessitated wading for hours at a time in slush and mud up to one's knees, but we were both rewarded with excellent specimens, and any trouble taken was amply repaid. An accompanying photograph shows a ram sitatunga lying in his natural swamp after having been dragged some hundreds of yards by the boys in order to obtain a more suitable position for photography. The lechwe, another water-loving antelope, was found to be very plentiful on the swamps bordering Lake Bangweolo, and we each secured good specimens without difficulty.

Animals of which we each secured specimens on this expedition were elephant, zebra, wart-hog, roan, sable, hartebeests, Crawshay's waterbucks, common waterbuck, tssessebe, pookoo, duiker, eland, oribi, and hyæna, whilst Halse secured a lioness and a hippo.

Notwithstanding the above, the trip was largely a failure, since we were unable, owing to the trouble with native carriers, to round the lake and so obtain black lechwe, and the country being unsuitable made it difficult to secure a good series of telephoto pictures.

A. H. B. KIRKMAN.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Biennial Dinner, 1914.

DEAR MR. EDITOR,—The list of acceptances appended to this letter includes all the names I have received up to this evening, and I must say I am much disdisappointed that it is not a longer one. I should be very much obliged if those who intend to come to the Dinner, and I feel sure there must be many, and who have not yet filled in and returned to me the invitation form sent them, would do so *as soon as possible*, so that in the next issue of the GAZETTE, on June 20th, there may be a list at least twice as long as the present one.

The publication of the names is an important element in the success of the Dinner, in that nothing is more likely to induce a doubting man to come than seeing that some of his old friends have decided to do so. Therefore, please, acceptances are wanted *now*, as there is only one more issue of the GAZETTE before the date of the Dinner, and in this issue will appear the final list of acceptances.

It is gratifying to record already the names of several men whom we have not seen at Guy's of recent years, owing to absence abroad. If anybody knows of others who are likely to be here at the time of the Dinner, I hope he will send me their names and addresses so that invitations may be sent to them.

The Committee look forward this year to seeing many men who have not attended these dinners hitherto, and I trust that such will be the case. If those who are coming, *and particularly the Vice-Chairmen*, will send post cards to their friends urging them to attend the Dinner, we shall be sure to have a good evening.

I should like to have the names of *all guests*, for, inasmuch as they must be Guy's men, their names are equally wanted for publication.

About a week before the Dinner a list of all who have signified their intention to be present will be sent to each individual who has accepted, so that he may mark on that list the names of those near to whom he would like to sit, and then return it to me. The tables will be arranged by these replies.

For the benefit of those who have mislaid their invitation form, a duplicate for use is to be found in the advertisement columns of this GAZETTE, or a second invitation form will be sent immediately on application to me.—I am, Sir, yours sincerely,

F. J. STEWARD.

98, Portland Place, W.
June 3rd, 1914.

LIST OF GUY'S MEN WHO HAVE SIGNIFIED THEIR INTENTION TO ATTEND THE DINNER.

1850—1870.

Bosworth, J. R.	Goodhart, Sir J. F.
Brookhouse, C. T.	Higgens, C.
Daniell, G. W.	*Savage, Sir G. H.
Dixon, J.	Tanner, J.
Elphinstone, R.	*Taylor, F.

1870—1880.

Beale, E. Clifford	*Mansell, E. R.
Brown, Thomas	*Murphy, Sir Shirley
Durham, F.	Shaw, C. Knox
Dring, W. E.	Symonds, C. J.
Ewart, J. H.	White, W. Hale
Golding-Bird, C. H.	Younger, E. J.
Howell, T. A. I.	

1880—1890.

Adeney, E. L.	*Holman, F. K.
Beard, F.	Lansdowne, R. P.
Bisshopp, F. R.	Maggs, W. A.
Blake, G.	Muspratt, C. D.
Blatherwick, H.	Newnham, W. H. C.
Broomfield, H. M.	Perry, Sir E. C.
Burghard, F. F.	Prall, S. E.
Cock, F. W.	Price, J. A. P.
Collington, F. A.	Rouw, R. Wynne
Counsell, H. E.	Sells, H. T.
Floyer, W. W.	Steele-Perkins, G.
Fripp, Sir A. D.	Stephens, Lockhart
*Hind, Wheelton	Randell, P. N.
Holloway, S. F.	*Wacher, S.

1890—1900.

*Allport, A.	Hopson, M. F.
Barrow, H. P. W.	Lister, T. D.
*Bligh, W.	McGavin, L.
Bolus, H. B.	Milbank-Smith, H.
Clarke, A. V.	Moon, R. O.
*Cleveland, A. J.	Moore, P. W.
Cloud, F. H. L.	Muriel, G. B.
Cooper, H.	Ormond, A. W.
Daldy, H. M.	*Spurrell, C.
Eason, H. L.	Spurrell, W. D.
Edwards, F. H.	*Steinhaeuser, J. R. p
Eyre, J.	Stevens, T. G.
Fagge, C. H.	*Telling, W. H. M.
Fawcett, J.	*Walker, F. E.
Fisher, W. H.	Way, M.
Fothergill, E. R.	Young, F. C.
Fremantle, F. E.	Young, J.

1900—1914.

Brookhouse, H.	Mills, C. H.
Browning, S. W.	Mollison, W. M.
Cameron, H. C.	Mullally, G. T.
Camps, P. W. L.	Munden, M. M.
Carlill, H. B.	Payne, O. V.
Chapple, H.	*Pinching, C.
Clarke-Cowen, E.	Price, P. S.
Cross, A. D.	Ryle, J. A.
*Depree, H.	Sandison, A.
Edmond, J.	*Seabrooke, A.
*Flower, N.	*Sheaf, E. W.
Forsyth, D.	Shipway, F. E.
French, H	Shufflebotham, F. H.
*Glanville, L. S. H.	Spriggs, N. J.
Goble, E. W.	Stebbing, G. F.
Goldie, E. G.	Steinbach, H.
Greenwood, A. A.	Taylor, M. B.
*Hammond, J. A. B.	Thompson, R.
Henderson, H. J.	Ticehurst, G. A.
Henson, W. J.	Tilbury, R.
Hughes, E. C.	Trethowan, W. H.
Hughes, F. P.	Wallace, F. H.
Johnson, W.	Watson, J. N.
Jones, C. E. M.	Whatley, J. L.
Kidd, W. S.	Wiltshire, H. P.
Layton, T. B.	Woodward, H. M.
*Lee, H.	*Wragg, E.
Macalister, J. H.	Vandermin, H. T.
Malleson, H. C.	Zorab, A.
Mann, H. C.	

* Denotes Vice-Chairmen.

Intratracheal Anæsthesia.

SIR,—I wish to draw attention to an error in my article in the GAZETTE of May 23rd, which occurs on page 189, line 26; it is the substitution of the word "maximum" for the word "minimum." The sentence should, of course, read "as a result, then, of these two factors, viz., even administration of the minimum amount of anæsthetic . . . . shock is considerably diminished."—I am, yours truly,

61, Queen Anne Street, W. FRANCIS E. SHIPWAY.
June 2nd, 1914.

Appointment.

Hildred B. Carlill, M.A., M.D. Cantab., M.R.C.P. Lond., appointed Assistant Physician to the West End Hospital for Diseases of the Nervous System, Welbeck Street, W.

Pass List.

Royal College of Surgeons of England.

DIPLOMA OF FELLOW.

FIRST PROFESSIONAL EXAMINATION, MAY, 1914.

A. M. Zamora.

Society of Apothecaries of London.

At examinations held recently the following candidate a ssed in the subject indicated:—

MIDWIFERY: R. J. Hearn.

Corrigenda.

In the last number of the GAZETTE, in the Pass List of the First Professional Examination for the Licence in Dental Surgery, Mr. G. F. H. Bloom's name was inadvertently spelt Broom. In the Final Examination, H. C. Corke should be substituted for C. J. Crocker.

Change of Address.

S. Hanreck, L.D.S., from 22 to 24, Carfax, Horsham.

A. H. B. Kirkman, F R.C.S. Ed., from Queenstown, South Africa, to Fowey, Cornwall.

Dr. H. C. Mann, to 49, Queen Anne Street, Cavendish Square, W.

Reviews, etc.

Tropical Medicine and Hygiene. By C. W. Daniels. M.B. Cantab., F.R.C.P. Lond. Vol. I. (Messrs. Bale & Danielsson.) 2nd edition.

The enormous extent of the field of tropical medicine makes it impossible to include all the work into one volume. This work is divided into three separate volumes which are of just the right size for comfortable reading, and make a pleasant contrast to the huge one volume type of text-book.

The first volume deals with the diseases due to protozoa and also with others, such as yellow fever, which are probably due to such organisms. The book is illustrated with many excellent plates and photographs, and contains useful tables classifying the relapsing fevers, the varieties of entamœbæ, and the different parasites of malaria.

Special consideration is given to the subject of prophylaxis, which plays such an important part in the war against tropical diseases. The measures described in this volume are mostly directed against arthropoda, insects, or arachnida, which act as intermediate or alternative hosts for the malarial and other protozoal parasites.

The book is delightfully easy to read, and we have no hesitation in recommending it to the notice of all students of tropical medicine.

PAPERS RECEIVED.—St. Mary's Hospital Gazette, Nursing Times, Journal of Clinical Research, M.S. Journal, Hospital, London Hospital Gazette, Middlesex Hospital Journal, St. Bartholomew's Hospital Journal, Polyclinic, Prescriber, Union Magazine, Broadway, Charing Cross Hospital Gazette, New York State Journal of Medicine, St. George's Hospital Gazette, The Stethoscope.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Annual Report of the Hospital for 1913, which has just been issued, provides much interesting reading. We see from the Treasurer's Report that the Income for the year has once more fallen below Expenditure, and the authorities have had to meet a deficit of almost £7,000 on the year's work. This deficit is due, chiefly, to a falling-off in the amount received from legacies, and to counteract it the Governors are appealing for an increase in the number and value of the Annual Subscriptions.

The plans for the proposed new buildings for the Children's Ward, the wards for the Special Departments, and the new Clinical Wards, which are to be added to the top of Hunt's Buildings are already prepared, but the work cannot be commenced until sufficient money can be obtained. The amount required is £60,000, and towards this fund only a few thousands have been contributed. The need for these new wards is very pressing, and we hope that the necessary funds will be received from some generous donors in the very near future.

WE have received a copy of the *Medical Journal of South Africa* for March of this year, containing an article on the association of Herpes Zoster and Varicella, by Dr. W. P. Le Feuvre. As will be remembered by some of our readers, Dr. Le Feuvre sent to the GAZETTE in April of last year some notes on a case of varicella occurring in a child within a short time of the appearance of shingles in one of the parents.

The details of the case were such as to suggest that the relationship between the two diseases was more than a mere coincidence. Dr. Le Feuvre's communication awakened considerable interest, and in the next few numbers of the GAZETTE five or six similar cases were reported. After that, the correspondence overflowed into the columns of the *British Medical Journal*, and numerous cases were reported there from widely separated parts of the country. In his paper, Dr. Le Feuvre has collected and analysed all the published cases which now number about 30, and the evidence he has gathered seems to prove fairly conclusively that there is a close etiological relationship between the two conditions. Whether this observation will lead us appreciably further in elucidating their pathology remains to be seen.

PERHAPS Dr. Hertz's remarks on the intimate relationship between gall-stones and pregnancy in the last number of the GAZETTE will be

equally productive. We publish this week notes of three cases showing this relationship, and, if the occurrence is more than accidental, similar cases must have been met with in the practice of many of our readers. If so, we will be very glad to publish an account of them.

THE Annual Garden Party will be held on Thursday, July 9th, at 3 p.m. The medals and prizes will be distributed by the Right Honourable Sir George Reid, High Commissioner for the Commonwealth of Australia. Sir George Reid's reputation as one of the most distinguished of all the public men whom Australia has produced, is too well known to need any comment from us, and we will be greatly interested to hear his views as a Colonial upon the School and Hospital through which so many Colonials have passed, and will, we have no doubt, continue to pass for very many years to come. The Laboratories and Museums, the Nurses' Home and the Wards will, as in previous years, be open to inspection from 3 to 5.30 p.m. Academic dress will be worn.

WE would remind all those of our readers who are Fellows of the Royal College of Surgeons that Guy's have a representative in the person of Mr. F. J. Steward for the forthcoming election to the Council of the College. Mr. Steward's reputation as a committeeman and his strong personality are such as to make him a very valuable representative of the Hospital and School on the Council, and we hope that all the Guy's Fellows will plump outright for him. We are sure that his election would be of great value both to the College and to Guy's.

WE hear with great pleasure that T. G. Stevens, M.D., F.R.C.S., M.R.C.P., has been appointed Obstetric Physician, with charge of In-Patients, to St. Mary's Hospital. Dr. Stevens has been Obstetric Physician to Out-Patients at St. Mary's since 1912, and is now promoted on the retirement of Dr. Gow. He was well known to, and very popular with, many generations of Guy's men during the years in which he was Demonstrator of Biology in the Medical School, and his appointment will be hailed with pleasure by all his old pupils. We offer him our hearty congratulations, and wish him every success.

THE Panel Committee for the County of London have undertaken to provide deputies for practitioners on the Panel during their temporary absence from their practices. Anyone willing to accept such engagement during the forthcoming summer months is invited to send his name to Dr. B. A. Richmond, Staple House, Chancery Lane, W.C. No fees will be accepted from the practitioner or the deputy in respect of any engagement which may be arranged.

THE Annual Swimming Sports will take place on Thursday, June 25th, in the Southwark Baths, commencing at 8 p.m. The events will be the same as in previous years, and will include a Nurses' Race, 66 yards Scratch and Handicap, 220 yards Scratch, Neat Diving and Plunging, Nurses' Diving, and a Water-Polo Match (Past *v.* Present). Mrs. C. E. Iredell has kindly consented to distribute the prizes. This entertainment is always one of the best and most popular of the annual sports, and we have no doubt that it will be equally good this year. The committee earnestly hope that there will be a big entry for all the events, and that there will be a record attendance of spectators. Tickets, price 2s. 6d. and 1s., may be obtained from the Hon. Secs., H. N. Eccles and C. H. Laver.

THE United Hospitals Athletic Sports will be held on Thursday, June 25th, in the Stamford Bridge Grounds. We hope that the Guy's men will give a good account of themselves, and wish them every success. We trust that more men will turn up to watch the event and cheer our representatives on. The attendance last year was very small indeed.

WE would once again call the attention of our readers to the Biennial Dinner to be held at the Connaught Rooms on Friday, July 3rd. We publish elsewhere in our columns the complete list of those who have up to the present

signified their intention of being present. We need not paint the delights of a Biennial Dinner to those who have already attended one, but we can assure those who have not that it is a time of very pleasant reunions. For those who have not yet made up their minds to be present there is still time if they will send in their names to the Hon. Sec., Mr. F. J. Steward, before Monday morning, June 29th, at the latest.

The Past *versus* Present cricket match will be played at Honor Oak Park on July 4th, the day following the Biennial Dinner. This date has been chosen in the hope that some of the country visitors, being already in town, will be tempted to stay over the next day and play for the Past. Mr. F. D. Saner is organizing the team, and he will be very pleased to hear from any old Guy's man who would care to take part. Letters to Mr. Saner should be addressed to the Hospital.

Obituary.

J. SIDDON CROOK, M.R.C.S.

We have heard with much regret of the death of Dr. J. Siddon Crook, which occurred at his residence, "Meadowbank," West Tarring, Worthing, on June 8th. Dr. Crook will be well remembered by many Guy's men of the early 'eighties. We tender his bereaved relatives our sincere condolences.

LOTTIE YEOMAN.

It is with very deep regret that we have to record the death of Miss Lottie Yeoman, a nurse of this hospital. After a long and painful illness, which she bore throughout with sweet patience and constant courage, she passed away on June 6th. Nurse Yeoman worked at Guy's from July, 1909, until September, 1912, acting latterly as head nurse in Out-Patients, and, after completing her training, devoted her attentions to privat nursing in association with the Guy's Hospital Nurses' Institute. She had a large circle of friends, and by her cheerful spirit won popularity for herself among her fellow-workers of both sexes. Only those who were with her during the sad close of her life can adequately testify to the wonderful fortitude of her nature.

Many will mourn her, but it is to her relations first of all that we would extend our warmest sympathies in their bereavement.

Some Notes on an Epidemic of Smallpox in Mauritius.

I read Dr. Jones's account of the outbreak of smallpox at Sydney, published in your issue of Feb. 28th, with great interest, and I must admit, with some relief, for rumours had reached me that this Colony was being held responsible for the introduction of that disease into Australia; a sailing ship having left Port Louis for Sydney just before we discovered our first cases, and she had several cases on board during the voyage. However, as Dr. Jones is satisfied that the source of the epidemic has been traced to the steward from Vancouver, and, as the two epidemics were so dissimilar, I think we may assume that Mauritius was not to blame.

The history of our outbreak was as follows:—Towards the end of February, 1913, hearing that chicken-pox of a severe type was getting very common, I proposed to His Excellency that it should be added to the list of notifiable diseases; this was done by Proclamation in the usual way, and on the 15th March we discovered five cases of confluent smallpox, one of them dead, in one yard in Port Louis. In four days we had unearthed fifty cases, all more or less severe, and found ourselves in presence of a well established epidemic of smallpox of a very severe type.

Luckily we have at our disposal some old barracks, built by the French in 1765, and these made an excellent C.D. hospital. They are only two miles from town, and consist of a central two storey block with outbuildings and dependencies, which conld be and were used as cubicles for the segregation of contacts and suspects. At the height of the epidemic we had 280 patients, 270 contacts, and 60 servants in these barracks at one time.

The steps taken to stay the disease were the usual ones, viz., vaccination, isolation of the sick in the C.D. hospital and segregation of the contacts, with the careful disinfection of all infected houses, clothing, &c. We vaccinated about 250,000 out of our 370,000 inhabitants, and we never had a second case in a house which we had once disinfected. Though the disease had such a start we got a grip of it before the end of May, stopped it in town by the end of August, and turned it out of the country by the end of December, after having 1,914 cases and 196 deaths.

Note the difference between the two outbreaks; Dr. Jones says that there is no vaccination law in New South Wales, in Mauritius we have one that compels every parent to have his child vaccinated before it reaches the age of ten months, yet Sydney gets off with a death rate of one per mille., whilst poor Mauritius has one of ten per cent. or thereabouts. Indeed, so potent was the virus that we had several second attacks (some of them fatal), and, a thing that I have never heard of before, we had two or three cases in which persons who had had the disease badly early in the epidemic, returned to the azaret a month or so later with a second attack, which

ran the usual course. Under these circumstances I think that no one can deny the fact that second attacks of smallpox do occur, and that in very severe epidemics that they are not rare. Our epidemic presented several peculiarities, the proportion of confluent and hæmorrhagic cases was high: there was no secondary fever, and the back-ache, usually so constant a symptom in the early stages, was not at all pronounced. The rash was in most cases typical, but there were cases in which it was so confluent that huge blebs formed, extending from shoulder to elbow, or from hip to knee. It appeared in the typical manner, first with a red flush on the forehead, papules then showed through the flush, which by the end of the first twenty-four hours spread down to the chest, and then over the rest of the body. The whole eruption took at least seventy-two hours to develop, that on the face and upper part of the body being pustular, whilst that on the rest of the body was still papular or not developed.

There were one or two cases of that particularly fatal form in which the rash appears early but soon aborts, the patient becoming a lobster red and dying within forty-eight hours from heart failure. Diagnosis in these cases was rather difficult at first, it was only when their contacts, who had not otherwise been exposed to contagion, developed ordinary smallpox within the incubation period, that we were able to suspect the nature of the rash.

Clinically, the most interesting part of the epidemic was the treatment we adopted and the accident that led us to adopt it. Quite early, in the month of March, in fact, a man, aged 30, was sent to the plague lazaret with a well developed plague bubo. He was treated as is usual here with intravenous injections of 10 c.c. of electrargol. The day after admission the smallpox rash appeared, it aborted, and the man recovered not only from the plague, but the smallpox as well. Talking this over with my friend, Dr. Keisler, the Medical Officer in charge of the hospital, we decided to try the effect of electrargol on confluent and hæmorrhagic smallpox, so we injected all the patients, who would allow us to do so, with 10 c.c. to start with, increasing the dose later to 30 c.c. every twenty-four hours. The result surprised us; the first injection stopped the development of the rash dead, pustules dried at once, papules remained papules, and where the rash had only reached the macular stage there it remained. In fact, so marked is the action of the drug, that after we had had some experience, we were able to say approximately at what stage of the disease any of these patients had received their first injection. Except in special cases it was only necessary to continue the treatment for three days. A study of the table that I annex shows that by adopting this method of treatment we reduced our death-rate from confluent smallpox from 69·1 per cent. to 11·4, and that from the hæmorrhagic variety from 88·8 per cent. to 25. The only objection to the use of this drug is that it is rather costly, but its use proved economical in the end, as it reduced our patients' stay in the hospital from about six weeks to about four, and what was of more importance to our patients, it minimized the skin destruction so much that those who had confluent attacks recovered with little or no disfigurement.

I should like, if you will allow me, to conclude with a few remarks about the use of colloid metals in plague. As I said above, it is our routine treatment here, and so far the results have been very encouraging. We did not get many patients to treat this year, but available figures show that in simple bubonic cases, provided we catch them within forty-eight hours of the commencement of the attack, we can expect cures in about 75 per cent. of our patients. Nothing, so far as I know, has yet been discovered that is of any use in either the bubonic or the pneumonic types. I have not a sufficient number of cases recorded yet to enable me to publish them, but if we have an outbreak next year I intend to give this treatment a full trial.

R. DENMAN,
Director, Medical and Health Department, Mauritius.

Nature of Case.	Treatment.	Number.	Cured.	Died.	Mortality. Per cent
Confluent ...	Simple ...	94	29	65	69·1
„ ...	Electrargol...	136	115	21	11·4
Hæmorrhagic	Simple ...	9	1	8	88·8
„ ...	Electrargol...	20	15	5	25·0

Change of Address.

Dr. F. W. Rowland, from 3, St. George's Place, Brighton, to Sunnybank, Belaugh, near Wroxham, Norfolk.

E. Rowland Fothergill, M.B., B.S., from Ravenstonedale, 38, Dyke Road, Brighton, to 16, Brunswick Place, Hove, Sussex. (Telephone, Hove 2247.)

Ray Edridge, M.R.C.S., L.R.C.P., from 18, Lawn Terrace, Blackheath, S.E., to Lynvale, St. Mark's Place, Bath. (Telephone, Bath 810.)

Edgar Smith, L.D.S., from 4, Hawarden Road, Colwyn Bay, to 6, Carlisle Parade, Hastings. (Telephone, Hastings 473.)

A. Mantell Daldy, M.D., from 17, Palmeira Road, Hove, Brighton, to 14, Palmeira Avenue, Hove, Brighton. (Telephone, Hove 2200.)

Douglas A. Mitchell, M.B., B.S., Surgeon R.N., to Royal Naval Hospital, Malta.

Dr. Bertram Soper, from 344, Clapham Road, S.W., to The Hawthorns, 193, Clapham Road, S.W.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Three Cases of Gall-stones associated with Pregnancy.

BY JOHN WATSON, M.R.C.S., L.R.C.P.

RECENTLY I have had three cases of pregnant women suffering from the most terrible flatulence and indigestion, absolutely unrelieved by drugs and diet; they are of interest in connection with the Clinical Lecture on Gall-stones, published in the last number of the GAZETTE. There were none of the usual symptoms of gall-stones, and consequently I put the symptoms down to severe digestive disturbance, the result of pregnancy. Two of the patients were relieved of their severer digestive disturbances on the termination of the pregnancies. None of them had ever suffered from severe indigestion before, and in no case have I been able to obtain any history of typhoid fever, or other infections likely to set up cholecystitis.

a. Six months later the first woman had repeated attacks of biliary colic. She was operated upon successfully, and has remained well since.

b. The second patient remained better for a year after the birth of her child. She then had a return of the digestive troubles, but no typical gall-stone symptoms. On examination, I found a small hard swelling just to the right of the umbilicus, which appeared distinct from the gall-bladder, and which I took to be a pyloric growth. She was forty-four. At the operation the swelling was found to be caused by a stone and a mass of adhesions. The stone was removed together with the gall-bladder, but the patient died on the third day.

c. The third case has just been prematurely delivered in the eighth month of her second pregnancy. She was quite fit and well until four weeks ago, when she had an attack of influenza, since which she has had violent and frequent attacks of epigastric pain. Flatulent indigestion occurs on taking practically any food, liquid or solid, and is unrelieved by drugs. Nothing abnormal is present in the lungs. She has mitral stenosis, which has not been improved by the violent indigestion. There is no marked tenderness over the gall-bladder, but slight discomfort on that side. A slight rise of temperature occurs every night. I thought it might be a pyelitis of pregnancy, but the urine was normal when examined bacteriologically. Yesterday she was distinctly jaundiced and there was bile pigment in the urine. The stools are rather unformed, but not really clay coloured. To-day the jaundice is clearing up and she appears better. It looks as if the influenza infection was the last straw and fired the mine in the gall-bladder, where there was already some deposit of cholesterol as the result of the pregnancy. This woman has never been bothered with indigestion except during her first pregnancy, but then it was not at all severe. I have never seen anyone with such a marked chloasma of pregnancy as she has.

Vocation *versus* Profession.

A Paper read before the recent Nursing Conference by Miss MARGARET FOX.

THAT such a title should be suggested for a paper on nursing seems to show that there are some people who do not believe a sense of vocation necessary to the making of a good nurse. They assert that a girl can enter a hospital for training in just the same way as she would enter a college or house of business, simply to learn all she can, to make a living, to be independent, to improve her social status, to take up an interesting career.

There are others who, without denying its desirability, are only too ready to say the sense of vocation has died out with the Victorian era, and that it simply does not exist in the outlook of the present-day nurse, that she is wordly-minded and grasping, that she is a lover of pleasure rather than work, that the welfare of her patients is less to her than the chance to enjoy herself, and that she is fast deserting the ranks of nursing for by-paths more alluring and more lucrative.

Some few even appear to think there is something antagonistic between the two ideas of "vocation" and "profession," that the religious spirit, the Divine call, is out of place in nursing and has no part or lot in the matter, that a nurse's business is solely and entirely to do with her patient's body to the utter exclusion of all else. Others—a minority, perhaps—hold that the spirit of true vocation is as present to-day as ever it was, but that it needs seeking out, encouraging, watering, and, moreover, that it is in danger of being destroyed by commercialism and driven out of sight by over much publicity.

What do we mean exactly by "vocation"? It is a sense of "call," a single heart, the feeling that one *wants* to do the thing undertaken and that nothing else ever can be so congenial. A sense of vocation dignifies one's work, magnifies one's office into something sacred; it gives strength, purpose, and the requisite feeling of "aloofness," so that one is less likely to be drawn aside from high endeavour into lesser by-paths. It deepens the sense of responsibility and sets the feet on sure ground.

It is not just a fanciful ideal. Vocation goes deeper than that. People with imagination and enthusiasm often fancy they have a vocation for nursing, their belief being based on no firmer foundation than that they have been successful at some First Aid Lectures, or have enjoyed belonging to a Voluntary Aid detachment and spent a delightful fortnight in camp. Such people may ride gloriously through the first few weeks of a probationer's career until disillusionment comes in the form of some disagreeable task, when they

suddenly find they are tired of the work and want to do it no longer. It is easy to see that these have not the true spirit of vocation.

Vocation signifies a "calling," and if one has received a genuine call, insistent, clear, and often repeated, the only possible thing to do resolves itself into a following of the guiding voice and a forsaking of all that hinders. It is another name for the spirit of true love for the work, a love that looks not only on one's own things, but also on the things of others, seeing them with their eyes, adapting itself to their needs, learning easily how to minister to their necessities. Unless one can do this it is useless to say one has a vocation for nursing. There is no vocation for music if one cannot learn the notes, for painting if no ability is shown to use the brush and mix the colours, for the ministry if one cares not for the souls of others.

There is nothing namby-pamby about a sense of vocation. It is rather the "spiritual oxygen of life, purifying the blood and giving health and vitality to the body corporate" of the entire profession. Nor is it a city of refuge into which the mean-spirited and cowardly may flee to hide themselves from the dust of conflict. On the contrary, it is only those largely imbued with such a spirit who take the trouble to right wrongs, who have the courage to speak out when they perceive things done contrary to the spirit of their profession, who will take the part of the weak against the strong, and contend earnestly for the right. No one denies the spirit of vocation to Florence Nightingale, but did she—to take only one item in her beneficent career—rest content with the half-hearted attempts of a feeble government to deal with the hospital horrors of the Crimean war? Nay, rather she moved heaven and earth to secure better conditions of food, clothing, and nursing for the sick, and rested not until in some poor degree her ideal was fulfilled. A true sense of vocation is satisfied only with the best that can be had. It has always marked the pioneers of any great movement, and in all the leaders of nursing it has been exemplified again and again.

The spirit of vocation is not incompatible with the professional spirit, or antagonistic to progressiveness. It is quite a mistake if the idea has come to be associated in our minds with a sickly sentimentality, over-much righteousness, a smoothing of pillows, a murmuring of prayers; rather, it means the practical energy, the muscular Christianity, the broad-minded grasp of things in general that alone can bring success to a nurse in the present day. No one's work is the poorer for having once seen a vision of it as it might be. Let us not forget that "where the vision faileth, the people perish," and that those who have seen visions and heard spiritual calls have often done wonderful things. Was there any sickly sentiment about Samuel called to his life-work as a child in the silence of the night? Who would ever have thought that the quiet temple-bred boy would develop into the fierce avenger, fearlessly rebuking a king, and hewing Agag in pieces with remorseless hands? Yet this was a man sternly fulfilling his vocation; and it is this same spirit of unflinching duty that possessed the ancient prophet which is still needed, something more even than a genuine love of nursing, to inspire our souls and strengthen our hands to attack and slay the many Agags in our midst to-day.

Some of these have been vigorously attacked during this Conference. Hydra-headed, many-sided, they have a way of springing up again and again even after receiving what has apparently been their final quietus. The Agag of an insufficient living wage for the nurse dependent on her profession for her daily bread; of bad housing, poor food, too long hours, too short holidays; the burden of over-work and scanty help; these and many others have been dealt with ably and to the point.

To attempt the divorce of the spirit of vocation from nursing means the plucking out the very golden heart of the profession; it is cutting of the living root that nourishes the whole tree, the drying up of the permeating sap of each green leaf. Barren, dry, and artificial indeed would it be if fed only from without, however fenced round with rules, watered with education, or planted in the most favourable surroundings. The sense of vocation in the heart is like a well of water, continually and spontaneously springing up, inciting to fresh effort. It remains, therefore, the thing to be desired and earnestly sought after in the profession of nursing. Without it we have the mere shell, the husk, the painted picture; with it we possess a pearl of great price; the corn of wheat, which, though it die, bringeth forth much fruit; the living soul instead of the painted presentment, full of energy and the life more abundant.

University of London Officers' Training Corps.

Medical Unit. "B" Section.

1. *Leave from Camp.*—Cadets are informed that, under War Office Regulations, leave from camp cannot be granted by the O.C. Contingent, except in cases of illness duly certified. Any cadet who is unable to attend camp must send in an application through me by July 1st, in order that this may be submitted to the War Office.

2. *Extract from Contingent Orders dated June 6th,* 1914.—To be Cadet-Lance-Corporals: Cadets L. V. Moore, W. F. McAlpin, W. W. King-Brown.

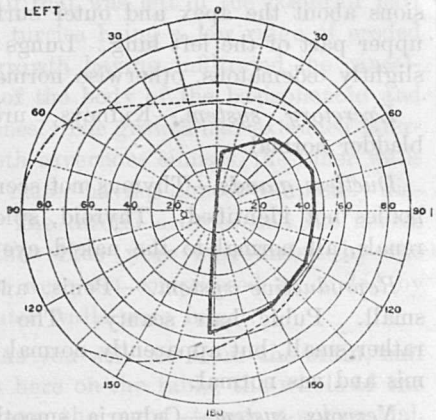
T. B. LAYTON,
Lieut., R.A.M.C. (T.),
O.C. "B" Section.

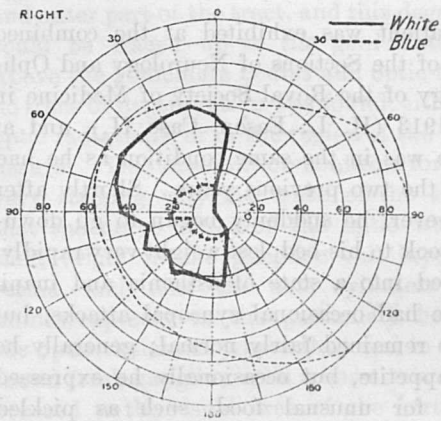
A Case of Tumour of the Pituitary Body.

CLINICAL LECTURE BY H. L. EASON.

GENTLEMEN,—Cases of tumours of the pituitary body are really not infrequent, but an autopsy on a case of pituitary tumour is sufficiently rare to be noteworthy, so I propose to-day to give some account of a case under my care during the last two or three years, and on which an autopsy, the first at Guy's for over thirty years, was made some months ago.

E. W., a butcher, first noticed failure of sight on the outer side of the field of vision in both eyes in 1910, at the age of 25. The loss of sight appeared to come on suddenly, and, as far as the patient could tell, did not progress further. He had constant vertical headaches, "rushings" in the head, and occasional fits, but no vomiting or vertigo. There was no albuminuria, polyuria, or glycosuria. He was first admitted to Guy's Hospital in March, 1911.





Condition on Admission.—*Eyes apparently normal, except for some pallor of the optic discs. Right eye, vision* 6/36; *left eye, vision* 6/9. *Complete bilateral temporal hemianopia. (Chart). Knee-jerks absent, thyroid isthmus present. Skin dry, hair dry and scanty. The patient is short and undeveloped, not looking anything like his age. Voice half broken, high-pitched. No hair on face; testicles normal, but very little pubic hair. Sensation normal. Extremely drowsy, and sleeps a great deal; when urged to get up, he does so for a few minutes, but soon returns to bed. Face cyanosed and pigmented, resembling the facies of Addison's disease to some extent. Blood normal, blood pressure* 100. *Wassermann reaction positive. A skiagraph shows some enlargement of the sella turcica. Weight, 7st.* 10*lb.*

The defect in the field of vision is highly significant, and emphasises the importance of taking a chart of the fields of vision in every case of optic atrophy or of cerebral tumour. You will remember that the temporal side of the field of vision, which was affected in this case, is represented by the nasal side of the retina, and that the fibres from the nasal half of the retina are those that decussate at the optic chiasm with those of the opposite side. Hence, to cause complete blindness of the temporal side of each field of vision the lesion must be situated in the immediate neighbourhood of the chiasm; and, practically without exception, only enlargements of the pituitary body, which is situated immediately behind the chiasm in the sella turcica, cause this characteristic visual defect.

On the strength of the temporal hemianopia, and the additional evidence of the skiagraph that the sella turcica was enlarged, a diagnosis of tumour of the pituitary body was therefore made. I want you also to bear in mind, for later consideration, the man's drowsiness and arrested physical and sexual development.

The patient was continually under observation, and until April, 1913, his condition remained

practically unchanged. In view of the positive Wassermann reaction he was treated with mercury and iodides, with no effect; he was also given thyroid and pituitary extracts for long periods, with no effect on vision, though his headaches were relieved and his general condition improved with pituitary extract. By the end of 1912 his weight had increased to 8st. 6lb.

In Feb., 1913, the fields of vision were again tested, and the field for white was practically the same as in 1911. The colour fields for the right eye were charted, and showed some diminution in the blue field. The fields for red and green were too small and indefinite to record, green being recognised as such only at the fixation point, and red called brown wherever visible.

The patient was exhibited at the combined Meeting of the Sections of Neurology and Ophthalmology of the Royal Society of Medicine in March, 1913 (H. L. Eason, Case II.), and at that time was in the same condition as he had been for the two previous years. Shortly after this, however, he suddenly began to go downhill; he took to his bed, lost weight very rapidly, and passed into a state of asthenia and inanition. He had occasional syncopal attacks, but otherwise remained fairly normal; generally he had no appetite, but occasionally he expressed a desire for unusual food, such as pickled onions, of which he ate heartily. Up to the last his vision did not fail entirely, the nasal side of the field of vision remaining fairly complete; there was no nasal discharge, epistaxis, or paralysis of any of the ocular muscles. The patient's sugar tolerance was never tested.

He died suddenly, apparently from heart failure, at 11 a.m. on June 18th, 1913. The autopsy was performed at 2 p.m. on the following day by Dr. French.

Autopsy. General appearance.—The body looks like that of a boy of about 16; the cheeks are smooth, but there is just a trace of a moustache at the corners of the lips. The size and shape of the skull and face are not abnormal. The body is considerably wasted, and there is no unusual deposit of fat anywhere. The skin is generally pigmented, especially at the points of pressure and tension, *e.g.*, over the anterior superior spines and the great trochanters.

Alimentary system.—The œsophagus, stomach, and intestines all normal. There is hardly any intra-abdominal fat, either in the mesenteries or the region of the kidney. The liver is small, yellowish in colour, and fatty. The gall-bladder contains thick dark green bile. The pancreas is normal in naked-eye appearance.

Circulatory system.—Heart rather small, and muscle a little brown in colour; no dilatation or valvular disease. Pericardium normal. Great vessels normal, if rather small. Cerebral vessels normal.

Respiratory system.—Some old pleural adhesions about the apex and outer surface of the upper part of the left lung. Lungs themselves slightly œdematous, otherwise normal.

Excretory system.—Kidneys, ureters, and bladder normal.

Ductless glands.—Thymus not seen. Carotid bodies not identified. Thyroid, spleen, suprarenals, all normal to the naked eye.

Reproductive system. — Penis and scrotum small. Pubic hair scanty. The testes also rather small, but apparently normal. Epididymis and vas normal.

Nervous system.—Calvaria smooth on both surfaces, and symmetrical, measuring a quarter of an inch at its thickest parts and three-sixteenths in most of its circumference. Sutures normal. Dura mater normal, and no external hydrocephalus. On removing the skull cap, a small amount of grumous yellow fluid was seen to be tracking upwards along the right Sylvian fissure from the base of the brain. The fluid was afterwards traced to a patch of yellowish degenerated brain substance on the under surface of the right frontal lobe. There was no flattening or other abnormality of the convolutions. The arachnoid and pia mater were normal. On lifting up the brain, a large tumour was seen in the neighbourhood of the interpeduncular space. The optic tracts and nerves were separated from each other by the whole

width of the tumour, and there was no visible trace of a chiasm, or of decussating nerve fibres. The brain was removed entire and hardened.

The base of the skull in the region normally occupied by the sella turcica was extensively eroded, so that on the removal of the brain and tumour a cavity was left measuring 39 mm. antero-posteriorly and 41 mm. transversely. The floor of the sella turcica was expanded and flattened, measuring 21 mm. antero-posteriorly and 26 mm. from side to side, but there was little erosion, and no communication either with the sphenoidal sinus or the naso-pharynx. The anterior clinoid processes were eroded, especially on the right side, and there was no trace of the optic groove. The dorsum ephippii and the posterior clinoid processes had entirely disappeared, all that was left of the posterior part of the sella turcica being a low ridge of eroded bone, the growth having infiltrated the cancellous tissue of the body of the basisphenoid and occipital bones. The growth had extended laterally into both cavernous sinuses, the inner walls of the dura mater having almost completely disappeared. The carotid arteries and the nerves lying in the sinus were surrounded by the growth, but were not compressed or eroded by it. The outer walls were intact.

Brain.—As you will see from the brain, half of which is here on the table, the whole of the space between the pons, temporo-sphenoidal, and frontal lobes is occupied by a crimson, soft, smoothly lobulated growth, springing from the hypophysis. The lower surface of the growth is very vascular, hæmorrhagic and diffluent, but anteriorly it consists of several lobes, one of which has passed into the olfactory sulcus on the right side, separating the gyrus rectus from the inner orbital convolution. The olfactory tract on this side is compressed between a lobule of the growth and the inner surface of the inner orbital convolution. The larger mass on the left side has entered the anterior part of the great longitudinal fissure, and has displaced outwards the inferior part of the orbital surface of the left frontal lobe.

The whole of the inter-peduncular space is filled up by the tumour, which extends backwards upon the pons almost as far as the origin of the fifth nerve. The temporo-sphenoidal lobes on each side are distinctly flattened, but are not infiltrated by the growth. The optic tract on each side winds round the tumour, that on the right side being apparently normal, that on the left being much flattened. Not a trace of the chiasm remains visible to the naked eye. The third and fourth nerves traverse the tumour, though they were apparently not affected during life. The sixth nerve was not involved, though the growth had invaded the cavernous sinus.

Half the brain has been very carefully examined by Dr. Johnson in the Pathological Department, with a view to tracing the degenerated nerve fibres in the optic tract. Sections of the optic tracts showed very extensive degeneration of the nerve fibres of the lower and outer part of the tract, and this degeneration could be traced up to the geniculate bodies. Above the geniculate bodies and optic thalamus no trace of degeneration was found, either in the optic radiations, or in the region of the calcarine fissure. This observation confirms for you in a very striking way the truth of the statement that the nerve fibres of the optic tracts have their origin in the ganglion cell layer of the retina, and that the axis cylinders proceed uninterruptedly to the geniculate bodies and the optic thalamus, where they end in dendrites round fresh ganglion cells whose axis cylinders proceed to the visual area of the cortex. The lower neuron of the optic tract, therefore, ends at the geniculate bodies and optic thalamus, and degeneration from a peripheral lesion does not proceed higher. No trace was found of any degenerated fibres connecting the geniculate bodies with the third nerve nucleus (the fibres that complete the pupillary reflex arc).

A section of the tumour showed an extensive overgrowth of the normal glandular tissue of the anterior lobe of the pituitary gland, the cells becoming malignant at the periphery and infiltrating all the lymphatics of the capsule with epithelial cells.

It now remains to give you a few very short notes on the physiology and pathology of the pituitary body, with a view of considering whether the case I have described to you shows

any characteristic features of disease of this gland. To those of you who would care to read up the subject in more detail, I would heartily recommend Harvey Cushing's admirable monograph,* which contains a wealth of clinical material and pathological comment that one can only admire and envy. Also the report of a discussion on diseases of the pituitary body at the combined sections of Neurology and Ophthalmology of the Royal Society of Medicine in March, 1913.

Anatomy.—The pituitary body consists of three parts—an anterior glandular part, derived from an invagination of the primitive buccal cavity, an intermediate part, and a posterior or nervous part. The anterior part is epithelial and glandular in structure, consisting of clear and granular epithelial cells, and is extraordinarily vascular. The intermediate part is also epithelial in character, but the cells are less coarsely granular and stain less deeply, and it contains numbers of hyaline masses. The posterior or nervous part consists of neurological tissue without true nerve cells, and contains numerous granular masses of hyaline substance derived from the intermediate part. The hyaline granules apparently pass into the infundibulum or stalk of the pituitary body, and so into the third ventricle and general cerebro-spinal circulation.

Physiology.—Experimental removal of the pituitary body usually causes death within two or three days, but some animals may survive and live some months. Young animals which survive extirpation of the gland have their growth and sexual activity arrested. Injection of saline extracts of pituitary substance intravenously causes constriction of all blood vessels of the body and increased secretions in the kidney and mammary gland. Indeed, pituitary extract is the most powerful galactagogue known.

Pathology of the pituitary body.—As in the analogous case of the thyroid gland, affections of the pituitary body may give rise to excessive secretion of the active principle of the gland (hyperpituitarism), or to diminished secretion (hypopituitarism). The changes caused by excessive or diminished secretion also vary if the disease commences before or after growth has ceased.

A. *Excessive secretion (hyperpituitarism) in infancy. Gigantism.*—Excessive activity of the pituitary gland before the epiphyses have joined gives rise to gigantism, which may be accompanied by enormous muscular and skeletal development.

Professor Keith (*Lancet*, April 15th, 1911) has shown that the skeletons of all the well-known giants in the various surgical museums exhibit most striking evidence of enlargement of the sella turcica, and, therefore, of pituitary over-growth.

Professor Cushing also gives a very detailed account of an American giant, 8ft. 3ins., of weight 275lbs., with very long arms like those of a gorilla, huge hands 10 inches long, and feet 16 inches long. At the autopsy a large collapsed cyst of the pituitary body was found.

B. *Hyperpituitarism, after adolescence and junction of the epiphyses. Acromegaly.*—This was the first condition due to disorder of the pituitary body to be recognised as a distinct clinical type, and was described by Marie in 1880. As most of you are aware, the chief characteristics of acromegaly are great enlargement of the lower jaw, nose, lips, and maxilla, spade-like hands and large feet, and very pronounced kyphosis. Patients with acromegaly may also complain of severe headaches, and constant sleepiness. In connection with acromegaly, Professor Keith also makes the interesting observation that acromegaly is probably an atavism or reversion to type, for the skulls of the Neanderthal skeletons, some of the earliest prehistoric men, are all acromegalic in type. The resemblance between acromegalic skulls and those of gorillas is also very great. Patients suffering from acromegaly may or may not have ocular symptoms; if there is any visual defect it is usually a bilateral temporal hemianopia.

C. *Diminished pituitary secretion (hypopituitarism) before adolescence.*—In cases of di-

* "The Pituitary Body and its Disorders," by Harvey Cushing, M.D. (Lippincott.)

minished pituitary secretion before puberty, the symptoms resemble those caused experimentally by removal of the pituitary body. Youths suffering from hypopituitarism remain sexually undeveloped, with very little or no pubic, axillary, or bodily hair, and become extraordinary fat, the adiposity being of the feminine type, the mammæ and buttocks showing the characteristic feminine outlines. Epilepsy is not uncommon from the intra-cranial pressure of the pituitary tumour.

The association of sexual mal-development and adiposity of the feminine type in men, is known as Fröhlich's syndrome, and was recognized as a definite clinical entity as late as about 1906. Excessively fat boys and girls are often of this type, and may remain permanently infantile.

D. *Adult Hypopituitarism.*—In adult life diminished pituitary secretion often leads to excessive obesity associated with sexual inefficiency, *adiposis dolorosa*. Associated with the obesity there is often drowsiness and polyuria, and carbohydrate tolerance. If a large dose of sugar is given to a normal adult there is a temporary glycosuria, but patients suffering from diminished pituitary secretion can tolerate enormous doses of carbohydrates. In a case quoted by Cushing, 400 grammes of sugar swallowed in one dose produced no glycosuria.

Though the various conditions due to disordered condition of the pituitary gland may be arranged in the above-mentioned classes, it must not be assumed that cases will always be found to exhibit the typical symptoms characteristic of any particular class. Cases may vary in so far as the local symptoms of a tumour, or the general systemic glandular symptoms, may predominate, and while excessive pituitary secretion may occur in the earlier stages of a tumour, the ultimate destruction of the gland by a growth or cyst may finally cause the symptoms of hypopituitarism to be superimposed on those of gigantism or acromegaly.

It has been presumed in the above sketch of the various disordered conditions of the pituitary body that the lesion is a tumour or cyst of the pituitary body itself, but it must also be borne in mind that almost any intracranial tumour, and particularly cerebellar tumours, may give rise to pituitary symptoms, either owing to the increased intra-cranial pressure causing obstruction to the blood supply of the gland, or, in the case of adult internal hydrocephalus following cerebral tumour, from distension of the infundibulum of the third ventricle pressing directly upon the optic chiasm and pituitary gland. I myself have seen two such cases within the last two or three years, and on each occasion it was easy to demonstrate at the autopsy the dilated infundibulum showing as a large cystic swelling in the interpeduncular space at the base of the brain. It is probable that the drowsiness, and fat round face that are often quoted as symptoms of cerebral tumour are conditions due to secondary affection of the pituitary body.

From the consideration of the above facts it is obvious, therefore, that the case we have been considering to-day was one of diminished pituitary secretion, commencing just at adolescence. The boy grew up normally till about the age of 16 or 18, and then a slow-growing tumour of the pituitary body destroyed or diminished its active secretion, and he remained permanently infantile. It was evident from the section of the gland that the tumour was originally benign, and only became malignant in its later stages. This would account for the very long history of the case, and the comparatively sudden ending.

Treatment.—Hitherto treatment, either by drugs or glandular extracts, or by operation, has not been generally successful. But that there is some balance between the pituitary and thyroid glands is certain, and in a few cases enlargement of pituitary body has been diminished by the administration of thyroid extract.

A case under my care as long ago as 1906 was a very striking example of this. A man, aged 30, came under my care in that year nearly blind, vision only remaining for perception of light on the nasal side of each field of vision. In view of the diagnosis of a tumour of the pituitary body, he was given thyroid extract, and his visual acuity and field of vision

improved up to normal in one eye within about a month, and to a very great extent in the other eye in the same period, and remained at that level for five years afterwards under the steady administration of thyroid gland. He has since disappeared from view, and I have not seen him since 1911. Other cases have also been recorded in which a temporary or permanent improvement in vision has followed the administration of thyroid extract. Operative treatment for the removal of tumours has hitherto not been very successful, the mortality being extremely high. The tumour can either be removed from beneath the base of the brain, through a large lateral opening in the skull, or as is a more modern method, by the nasal route through the sphenoidal sinuses. The cases in which most success has been obtained are those in which the lesion of the pituitary body is a cyst, the puncturing or emptying of which has produced immediate relief of symptoms. In many cases all that can be done is an ordinary cerebral decompression operation for the relief of ocular symptoms or of intra-cranial tension. In the case under my care it was obvious post-mortem that in the later stages of the disease, at any rate, a removal of the growth would have been absolutely impossible, and as the boy retained useful vision to the last, and never suffered from symptoms of intra-cranial tension, I think we were quite justified in considering an operation inadvisable.

Appointments.

Medical School Appointments.

JULY—SEPTEMBER, 1914.

Clinical Assistants.—Messrs. L. Muir Smith, H. P. Whitworth, C. Lambrinudi, C. Dean, F. E. R. Laborda, P. D. Scott.

Clinical Assistants in Medical Wards.—Messrs. W. M. Lansdale (Dr. Hale White); H. L. Messenger (Sir Cooper Perry); L. R. Pickett (Dr. Shaw).

Clinical Assistants in Surgical Wards.—Messrs. D. O. Richards (Sir W. Arbuthnot Lane); G. L. Attwater (Mr. Dunn); N. H. W. Saw (Mr. Steward).

Dressers in Special Departments:—

Throat and Ear, Children, Genito-Urinary.—Messrs. C. W. W. Baxter, J. E. Clark, J. Kyle.

Throat and Ear, Skin, Orthopædic.—Messrs. J. G. Stevens, M. J. T. Wallis, G. B. Tarring.

Eye, Nervous System.—Messrs. A. L. Punch, G. S. B. Long, G. D. Gripper, W. A. Young (Mr. Eason); C. E. Petley, J. Stephenson (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. C. C. G. Gibson, A. C. M. Coxon, C. H. Medlock, A. F. Rook, S. W. Coffin, M. Chadwick, J. F. H. Stallman, R. A. Holmes (Mr. Bellingham Smith); R. Curle, L. R. Broster, C. P. Symonds, K. L. Bates, R. W. P. Jackson, N. E. Kendall, E. W. Bowell, E. J. Cooke (Mr. Chapple).

Surgeons' Dressers.—Messrs. J. J. Conybeare, L. H. B. Evans, V. R. Hirsch (Sir W. Arbuthnot Lane); F. A. Knott, C. H. Edwards, V. E. Lloyd (Mr. Dunn); G. Noott, D. H. A. Galbraith (Sir Alfred Fripp); J. G. Jones, E. Biddle, K. N. Purkis (Mr. Steward).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. A. Traill, E. S. Bowes, E. C. de M. Morgan (Dr. Hale White); L. P. Waghorn, A. G. East, W. D. Newland (Sir Cooper Perry); A. D. Marston, A. W. Cocking, N. H. S. Maelzer (Dr. Shaw); E. M. Litchfield, J. B. Fairclough (Dr. Fawcett). H. M. Gray, J. A. M. Alcock, E. N. Glover, W. J. Vance, J. Victory, J. E. E. de Robillard, C. T. Helsham, R. H. C. Pryn, G. E. L. Simons, H. J. Bensted, K. M. Woodruff.

Assistant Surgeons' Dressers.—Messrs. C. H. Laver, I. R. R. Brogden (Mr. Fagge); J. F. Carter-Braine, P. G. McEvedy (Mr. Rowlands); A. Bulleid (Mr. Turner); W. H. A. Pratt, D. M. P. Whitcombe (Mr. Hughes); W. G. S. Neely (Mr. Davies-Colley).

Surgical Ward Clerk.—Mr. T. E. Micklem.

Civil.

Douglas Allan has been appointed Hon. Assistant Surgeon to the Durham County and Sunderland Eye Infirmary.

L Gwyn-Davies to be House-Physician at the Westminster Hospital, S.W.

C. D. Killpack, M.B., B.S., has been appointed Medical Officer to the Post Office at Hayward's Heath, Cuckfield and Lindfield.

A. H. Miller, M.D. Camb., M.R.C.P. Lond., has been appointed Joint Pathologist to the Salford Royal, Manchester Children's, and Manchester Northern Hospital.

J. G. Porter Phillips, M.D., M.R.C.P. Lond., as Resident Physician and Medical Superintendent to Bethlem Royal Hospital.

Military.

Lieut.-Col. G. H. Knapp, S.A.M. Corps, O.C. Medical Training Department, Tempe, Bloemfontein.

Army Medical Service.

Major Harold P. W. Barrow, R.A.M.C., to be a Deputy Assistant Director-General at the War Office, *vice* Lieutenant-Colonel B. H. Scott, dated May 1st, 1914.

Honours.

On behalf of the Queen of Bulgaria, Mr. Mineoff, Secretary of the Bulgarian Legation in London, has handed to Dr. G. W. C. Hollist the Red Cross Medal for services rendered by him during the recent Bulgar-Turkish war.

Pass List.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, May, 1914.

Bennett, T. I.	Wills, A.
Evans, H. W.	Wilson, O. R. L.
Tanner, W. E.	Witts, C.

SUPPLEMENTARY PASS LIST.

The following candidates have passed in one of the two groups of subjects :—

Group I.

Sherris, C.

Group II.

Eccles, G. D.	Smith, P.

Royal College of Surgeons of England

FINAL FELLOWSHIP, May, 1914.

Cook, F.	Jefferson, J. C.
Gardiner, H.	Maxted, G.
Glendining, V.	Mullally, G. T.

At a meeting of the Council of the Royal College of Surgeons of England on May 14th the Diploma of M.R.C.S. was conferred on the following candidates :—

Annesley, F. D.	Muir-Smith, L.
Dean, C.	Savage, P.
Diay, I. F.	Sharpe, H.
du Vergé, P. G. L.	Venugopal, S. B.
Hanafy, M. Z.	Whitworth, H. P.
Lawson, F. W.	Wills, A.
Martin, E. G.	

PAPERS RECEIVED.—Prescriber, Hospital, Clinical Journal, University College Hospital Magazine, St. Thomas's Hospital Gazette, Nursing Times, Polyclinic, St. Bartholomew's Hospital Journal, New York State Journal of Medicine.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

THE BIENNIAL DINNER, July 3rd, 1914.

DEAR MR. EDITOR,—I am much obliged to you for inserting my previous letters about the Biennial Dinner. I now send you the list of those who have, so far, signified their intention to be present. Dinner tickets will shortly be sent to all those whose names appear in the accompanying list, and I would ask everyone to return to me *immediately* the notice accompanying the ticket as therein requested. If this is done I hope to be able to arrange that each diner will find himself seated among his own particular group of friends. On the other hand, it will be impossible for me to carry this satisfactorily into effect in the case of those whose replies reach me later than the evening of Friday, June 26th. Of course, if there are any Guy's men who have been unable, so far, to decide to come, and yet find that at the last they can do so; or if there are any who, on looking over the accompanying list see names which induce them to come, I hope they will apply to me *at once* for a seat, informing me in their letter near whom they would like to sit. I will then do the best I can for these late comers, who, though late in applying, will be none the less welcome.

I am, Sir,
Yours sincerely,
F. J. STEWARD.

98, Portland Place, W.
June 18th, 1914.

LIST OF GUY'S MEN WHO HAVE SIGNIFIED THEIR INTENTION TO ATTEND THE DINNER.

1854—1869 (inclusive).

1854	†Dixon, J.	1868	Goodhart, Sir J. F.
1856	Daniell, G. W.		Higgens, C.
1860	Tanner, J.		*Taylor, F.
1863	Ray, E. R.	1869	Durham, F.
1865	Elphinstone, R.		Gillingham, A.
1866	Bosworth, J. R.		Hogg, R. B.
1867	*Savage, Sir G. H.		Taylor, W. Bramley
	Wiseman, J. Greaves		Townsend, T. S.
1868	Brookhouse, C. T.		

1870—1879 (inclusive).

1870	*Murphy, Sir Shirley	1876	*Mansell, E. R.
1871	Ewart, J. H.		Symonds, C. J.
	Younger, E. G.	1877	Jones, J. M. Bowen
1872	Golding-Bird, C. H.		Uhthoff, J. C.
	Turner, Sir George	1878	Beale, E. Clifford
1873	Langdale, H. M.	1879	White, W. Hale
1875	Brown, Thomas		Howell, T. A. I.
1876	Dring, W. E.		

1880—1889 (inclusive).

1880 Newnham, W. H. C.
Steele-Perkins, G.
1881 Adeney, E. L.
Ashwell, H. G.
Blatherwick, H.
Lane, Sir W. Arbuthnot
Milligan, R. A.
1882 Cock, F. W.
Dunn, L. A.
*Hind, Wheelton
Meyer, C. H. V.
Price, J. A. P.
Sells, H. T.
Stephens, Lockhart
Worthington, S.
Wright, Holland
1883 Floyer, W. W.
Jones, M. Parry
Pillin, H. L.
Shaw, L. E.
1884 Brogden, R. W.
Counsell, H. E.
Maggs, W. A.
Muspratt, C. D.
1884 Pitt, G. Newton
1885 Beard, F.
Bisshopp, F. R.
Farr, E. A.
Green, Albert
Perry, Sir E. C.
Price, A. E.
1886 Burghard, F. F.
Prall, S. E.
Rowell, G.
*Wacher, Sidney
1887 Black, George
Bromfield, H. M.
Bryden, F. W. A.
Holloway, S. F.
Randell, P. N.
1888 Brett, W. G.
Collington, F. A.
*Holman, F. K.
Roberts, J. Lloyd
Robertson, John
Smith, G. Bellingham
1889 Fripp, Sir A. D.
Lansdown, R. P.
Rouw, R. Wynne

1890—1899 (inclusive).

1890 Clowes, N. B.
Fawcett, J.
Russell, J. W.
Samways, D. W.
*Spurrell, Charles
Stevens, T. G.
Tubby, A. H.
1891 Craig, Maurice
Emmet, J. W.
Hopson, M. F.
Jewell, J. W. F.
Spurrell, W. D.
Winslow, W.
Young, John
1892 *Bligh, W.
Bolus, H. B.
Brown, R. King
Daldy, A. M.
Fisher, W. H.
Lister, T. D.
May, P. M.
Young, F. C.
1893 Cooper, Harry
Edwards, F. H.
Eyre, John
1894 *Allport, A.
Hovenden, A. C.
Munro, H. A.
Robinson, W. E.
1895 Clarke, A. V.
Fothergill, E. R.
1895 Hovenden, G. S.
*Steinhaeuser, J. R.
1896 Alexander, A.
Busteed, J. H.
Fagge, C. H.
Milbank-Smith, H.
Moon, R. O.
Muriel, G. B.
Ormond, A. W.
Scott-Turner, A.
Spon, H. J.
1897 *Cleveland, A. J.
Cloud, F. H. L.
Dudgeon, H. W.
Fremantle, F. E.
Godson, F. A.
O'Meara, E. J.
Thorneley, M. H.
Way, Montague
1898 Barrow, H. P. W.
Eason, H. L.
Henson, W. J.
McGavin, L.
Moore, P. W.
Swan, R. H. J.
*Telling, W. H. Maxwell
1899 Beddard, A. P.
Dowsett, E. B.
Miller, A.
Payne, J. L.
*Walker, F. E.

1900—1913 (inclusive).

1900 Camps, P. W. L.
Clarke-Cowen, E.
Forsyth, David
French, Herbert
Goble, E. W.
Nicholls, F. J.
Shufflebotham, F. H.
Thomas, T. P.
1901 *Hammond, J. A. B.
Lewin, George
Steele-Perkins, J. S.
Thompson, Ralph
Tilbury, R.
1902 Claxton, E. I.
Evans, George
Jackson, F. D. S.
*Pinching, Charles
Shipway, F. E.
Tipping, H.
Trail, D. H.
Whatley, J. L.
Wiltshire, H. P.
1903 Brailey, A. R.
Brown, H. S.
Cooper, J. S.
Fawssett, Frank W.
*Glanville, L. S. H.
Goldie, E. G.
Goss, John
Greenfield, Dudley C.
Iredell, C. E.
Mann, H. C.
Spriggs, N. I.
Wacher, Harold
Wallace, F. H.
1904 Chisolm, R. A.
Hughes, E. C.
Hughes, F. P.
May, W. N.
Mollison, W. M.
Routley, E. W.
Ticehurst, G. A.
Woodward, H. M.
1905 Cameron, H. C.
Crofts, A. D.
Hardy, G. F.
Payne, O. V.
Taylor, M. Bramley
1906 Berry, A. W.
Daw, S. W.
Goodhart, G. W.
Laidlaw, P. P.
Layton, T. B.
Macalister, G. H.
Malleson, H. C.
*Sheaf, E. W.
Stebbing, G. F.
Trethowan, W. H.
1906 Turner, T.
Vandermin, H. T
Wedd, B. H.
*Wragg, E.
Zorab, A.
1907 Aubrey, H. P.
Carlill, H. B.
Clark, A. J.
*Flower, Norman
Henderson, H. J.
Jones, C. E. M.
Rippman, C. H.
Ryffel, J. H.
Watson, John N.
1908 Ball, M. E.
Brookhouse, H.
Chapple, Harold
Davies-Colley, R.
Dobson, M. R.
Ewing, A. W.
Hole, K. H.
Johnson, W.
Price, P. Seymour
Syms, G. F.
1909 Browning, S. W.
Collins, E. A.
Greenwood, A. A.
Kidd, W. S.
*Lee, H.
Mills, C. H.
1910 Edmond, J.
Poulton, E. P.
Saner, F. D.
1911 Barber, H. W.
*Depree, H. T.
Heaton, T. B.
McNair, A. J.
Marshall, Geoffrey
Munden, M. M.
Mutch, N.
Sandison, A.
Steinbach, H.
Stewart, B. H.
1912 Daw, Hubert
Gatley, C. A. R.
Fry, W. Kelsey
*Seabrooke, A.
1913 Clifford, A. C.
Eagleton, A. J.
Evans, H. W.
Ryle, J. A.
Taylor, Eric
Wickenden, Stanley
——
Cock, Stanley
Dresing, H. G.
Jones, O. G. Parry
Lowry, J. M.

† Date of Qualification.
* Vice-Chairman.

Also Viscount Goschen, Colonel F. A. Lucas, and the Editor of the GUY'S GAZETTE.

The late Dr. Pye-Smith.

DEAR SIR,—The reference to the pupils of Dr. Pye-Smith's father who came on the Guy's Staff is, Mr. Rutherford Pye-Smith writes me, not quite correct. The names should be Habershon, Pavy, Phillips (who died young), and his own son.—Yours very truly,

58, Portland Place, W. C. J. S.
June 9th, 1914.

A Case of Typhoid Fever with an unusual Blood Count.

DAVID THOMAS, æt. 4, admitted under Dr. Beddard, into John, 7th April, for malaise and diarrhœa, of a week's duration; also on the day before admission patient had vomited twice and had some abdominal pain, especially on the left side.

Among previous illnesses were measles, whooping-cough, and mumps.

On admission.—P. 136, T. 102·2°, R. 28. Patient seemed comfortable except for some abdominal pain on the left side, and did not appear very ill. The various systems seemed quite normal, and abdominal examination proved negative. Urine normal.

A blood count showed—

White cells 80,000.

		per cent.
Differential	Lymphocytes ...	80.
	Polymorphs ...	15.
	Eosinophils ...	5.

On this, the case was thought to be one of pneumococcal septicæmia rather than typhoid fever.

April 8th, 1914.—There has been no more diarrhœa since admission.

April 9th.—A positive Widal was returned; agglutination in half-an-hour with dilutions of 1 in 20 and 1 in 200. Dr. Beddard remarked on the unusual blood picture, and said that children often finished the pyrexial part of their typhoid in a few days, as was apparent in this case. Pulse, 112; temperature, 102·2°; respiration, 25. Blood counts were performed with the following results :—

April 9th.—White cells, 60,000; red cells, 4,500,000. Differential: lymphocytes, 70 per cent; polymorphs, 20 per cent.

April 10.—White cells, 40,000. Lymphocytes, 60 per cent. Pulse, 110; temperature, 99°; respiration, 24.

			Per cent.
April 11.—White cells,	35,000.	Lymphocytes,	70
„ 12. „	30,000.	„	68
„ 13. „	32,000.	„	65
„ 14. „	31,000.	„	85
„ 15. „	32,000.	„	86
„ 16. „	30,000.	„	88
„ 17. „	32,000.	„	85

„ 18.—A negative Widal was returned.

Dr. Eyre explained the above, the giving of a positive and, then, shortly after, a negative Widal, as occurring either in very bad cases or where there was no specific agglutination present. Cultivation of the blood remained sterile after 72 hours' incubation.

Blood counts still showed an abnormal leucocytosis and lymphocytosis as follows :—

			Per cent.
April 18.—White cells,	25,000.	Lymphocytes,	60
„ 19. „	22,000.	„	55
„ 20. „	22,000.	„	50
„ 21. „	20,000.	„	60
„ 22. „	18,000.	„	50
„ 23. „	17,000.	„	50
„ 24. „	17,000.	„	40
„ 25. „	16,000.	„	40
„ 26. „	15,000.	„	40
„ 28. „	13,000.	„	40

Pulse, 100; temperature, 98·6°; respiration, 24.

April 30.—All this time patient has been quite fit and well, bowels being regular and motions normal, temperature normal. A typhoid diet has been maintained.

May 2nd.—For three days patient has had polyuria, and passed very large quantities of urine during the day and night also. On examination, specific gravity was 1012. No abnormal constituents, and no obvious bacilluria, nor excess of chlorides noticed.

Widal's test failed to show any specific agglutinins when tested against B. typhosis, B. enteritidis of Gäertner, and paratyphoid A.

In 5 per cent. solution the serum gave a slight agglutination reaction, but not a specifie one, with B. typhosus.

The blood counts have been coming down.

		per cent.
May 2nd.—White cells, 12,000		
	Lymphocytes	50.
	Eosinophils	9.
	Polymorphs	41.

No additional symptoms presented, the polyuria having terminated. Patient seems quite fit and well.

The literature on the subject says the following :—

Goodall: "There are certain cases of typhoid in which there is a persistent leucocytosis throughout with no discoverable complications."

Dirschfield in Allbutt, says: "Counts above 10,000 are rare in typhoid, and differential counts show a reduction of polymorphs to 60 per cent., 50 per cent.; also that an increase of large mononuclear leucocytes generally shows the incidence of some complications."

Thinking that perhaps the adult count might be different from that of children, the cases of typhoid under twelve admitted into hospital during the last two or three years were referred to, from which it was shown that a leucopenia was rare, the normal count of 7,000–8,000 leucocytes appearing in nearly all the cases, and there were no cases with a count over 12,000 that had not severe complications.

Thanks are due to Dr. Beddard for allowing these notes to be printed. C. S. L. R.

Notices.

University of London Club.

At the Statutory General Meeting of the University of London Club, held at the University on Wednesday, June 10th, 1914, Lord Rosebery, Chancellor of the University, was elected President of the Club, and the following were elected Vice-Presidents :—Sir Thomas Barlow, Sir Robert Blair, Sir John Rose Bradford, Dr. Sophie Bryant, Sir Edward H. Busk, Mr. Clifford B. Edgar, Lord Emmott, Sir Rickman J. Godlee, Sir Alfred Pearce Gould, Dr. W. P. Herringham, Prof. M. J. M. Hill, Sir Alfred Hopkinson, Sir Joseph Larmor, Sir Oliver Lodge, Sir Philip Magnus, Sir Henry A. Miers, Lord Moulton, Sir William Ramsay, Sir Henry E. Roscoe, Sir William A. Tilden, Prof. H. H. Turner, and the right Hon. T. McKinnon Wood.

The Committee reported that 910 original Members of the Club had been elected, 6 applications being still under consideration. The 910 original Members include 554 Town Members and 356 Country Members ; 709 men and 201 women. The principal professions represented are :—Teachers (including 150 Teachers of the University), 420 ; Doctors and Surgeons, 135 ; Civil Servants, 66 ; Lawyers, 64 ; Ministers of Religion, 53 ; Engineers, 27.

The following have been elected Honorary Members of the Club :—Rt. Hon. A. H. D. Acland, Rt. Hon. A. J. Balfour, Rt. Hon. Viscount Bryce, of Dechmount, Sir William Crookes, and the Rt. Hon. Viscount Haldane, of Cloan.

The Committee further reported that Mr. T. Ll. Humberstone had been appointed the first Secretary of the Club ; and that it was hoped that the Club-house at 19 and 21, Gower Street, would be open in July or soon afterwards.

After the reception of the report of the Committee, a silver salver was presented to the Club by representatives of the United Faculties and Graduates Club "on the long-desired occasion of the opening of a University Club-house."

Temporary Office,
University of London,
South Kensington, S.W.
June 12th, 1914.

Royal College of Physicians of London.

Dr. E. Goodall will deliver the Croonian Lectures on Tuesdays and Thursdays, June 18th, 23rd, 25th, and 30th, at 5 o'clock, at the College, Pall Mall East. Subject : "Modern Aspects of Certain Problems in the Pathology of Mental Disorders."

(By order of the President),
W. FLEMING,
Bedell and Secretary.

The Wellcome Historical Medical Museum.

The Historical Medical Museum, which was founded by Mr. Henry S. Wellcome in connection with the Seventeenth International Congress of Medicine, was re-opened on May 28th as a permanent institution in London. It is now known as the "Wellcome Historical Medical Museum," and is open daily from 10 a.m. to 6 p.m., closing at 1 p.m. on Saturday ; entrance, 54A, Wigmore Street, Cavendish Square, W. Since closing last October the collections in the Museum have been considerably augmented and entirely re-arranged. Many objects of importance and interest have been added, which it is hoped will increase the usefulness of the Museum to those interested in the history of medicine. Members of the medical and kindred professions are admitted on presenting their visiting cards. Tickets of admission may be obtained by others interested in the history of medicine on application to the Curator, accompanied by an introduction from a registered medical practitioner. Ladies will be admitted, *only* if accompanied by a qualified medical man.

His Majesty's Indian Medical Service.

A competitive examination for not less than thirteen appointments to His Majesty's Indian Medical Service will be held at the Royal Army Medical College, Millbank, S.W., and at the Examination Hall, Queen Square, Bloomsbury, on the 27th July, 1914, and five following days.

Copies of Regulations for the Examination, together with information regarding the pay, retired pay, etc., of Indian Medical Officers, can be obtained on application to the Military Secretary, India Office, London, S.W. Application for admission to the examination, with the necessary certificates, must be sent so as to reach him on or before the 14th July, 1914.

PROGRAMME OF EXAMINATION.

AT THE ROYAL ARMY MEDICAL COLLEGE, MILLBANK.

Monday, 27th July, 1914.—Practical Pathology, from 2.30 p.m.

AT THE EXAMINATION HALL.

Tuesday, 28th July, 1914.—Clinical Medicine and Examination of Specimens, from 10 a.m. Paper in Medicine and Therapeutics, from 2 to 4 p.m. Paper in Surgery and Diseases of the Eye, from 4.30 to 6.30 p.m.

Wednesday, 29th July, 1914.—Clinical Surgery, from 10 a.m. Paper in Pathology and Bacteriology, from 2 to 4 p.m. Paper in Applied Anatomy and Physiology, from 4.30 to 6.30 p.m.

Thursday, 30th July, 1914.—Clinical Surgery, from 10 a.m. Paper in Materia Medica, Pharmacology, and Toxicology, from 2 to 4 p.m. Paper in Midwifery, Diseases of Women and Children, from 4.30 to 6.30 p.m.

Friday, 31st July, 1914.—Surgical Operations, from 9.30 a.m. Oral Examination (half of the candidates), from 2.30 p.m.

Saturday, 1st August, 1914.—Oral Examination (remainder of the candidates), from 9.30 a.m. Examiners to meet in conference on termination of the examination.

ALLOTMENT OF MARKS.

1. In Medicine and Therapeutics—1,200.

2. In Surgery and Eye Diseases—1,200.

3. In Pathology and Bacteriology—900.

4, 5. In Materia Medica, Pharmacology and Toxicology, and in Midwifery and Diseases of Women and Children—600 in each of the two subjects.

6. In Anatomy, etc.—600.

To qualify, Candidates must obtain at least one-third of the total number of marks allotted in each subject, and one-half of the aggregate marks for all subjects.

EDMUND G. BARROW, *General,*
Military Secretary.

India Office, Whitehall, S.W.
June, 1914.

Lawn Tennis.

INTER-HOSPITAL CUP TIES.

The Inter-Hospital Cup Ties were played at Honor Oak Park on Thursday, Friday, and Saturday, June 4th, 5th, and 6th, and resulted for the seventh year in succession in a victory for Guy's, who were never extended, and won all their matches by a comfortable margin.

R. Curle was in great form throughout, and is to be congratulated on having played in seven winning teams, which must be a record for any Inter-Hospital event, and one which will probably stand for some considerable time.

Thursday, June 4th, First Round.—St. Thomas's, Middlesex, and London drew byes. Guy's beat St. Bart.'s by 8 matches to 1, 6 being left unplayed.

GUY'S v. ST. BART.'S.

SINGLES.

A. Traill beat G. S. Stathers...	6-2, 3-6, 6-2
L. A. Graham beat A. H. Little... ...	6-1, 2-6, 7-5
W. R. Reynell beat R. R. Powell...	6-3, 6-1
R. Curle beat J. W. Stretton	6-4, 3-6, 6-2
N. Garrard beat C. S. Atkin	6-1, 6-3
C. E. Petley beat F. D. Batt	6-2, 6-1

DOUBLES.

Reynell and Traill beat Stathers and Little	6-4, 6-2
Graham and Curle beat Atkin and Batt ...	6-2, 6-2
Garrard and Petley lost to Powell and Stretton	6-3, 3-6, 3-6

Friday, June 5th, Second Round.—St. Thomas's beat Middlesex by 8 matches to 1; Guy's beat London by 9 matches to 0, 6 being left unplayed.

GUY'S v. LONDON.

SINGLES.

A. Traill beat A. A. Fyzee	6-1, 6-1
L. A. Graham beat L. C. Somerville... ...	6-1, 6-0
W. R. Reynell beat H. G. Brodbridge ...	6-1, 6-0
R. Curle beat L. H. Dardier...	6-2, 6-4
N. Garrard beat E. A. Leak...	6-0, 6-1
C. Petley beat C. R. Reckitt...	6-8, 6-1, 6-3

DOUBLES.

Reynell and Traill beat Fyzee and Somerville	6-0, 6-2
Curle and Graham beat Brodbridge and Dardier	3-6, 6-1, 6-2
Garrard and Petley beat Leak and Reckitt	6-4, 6-1

Saturday, June 6th, Final.—Guy's beat St. Thomas's by 8 matches to 1, 6 being left unplayed.

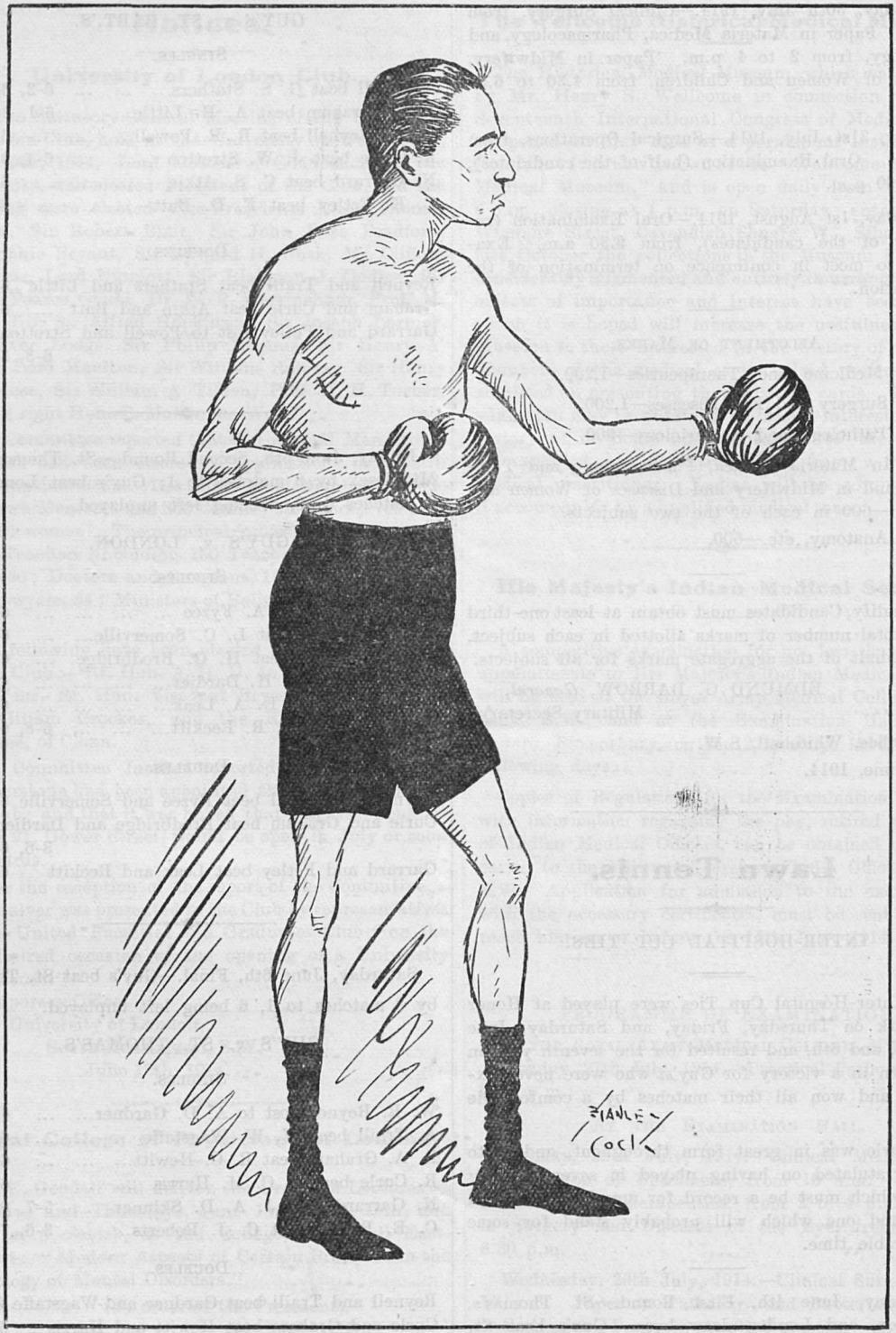
GUY'S v. ST. THOMAS'S.

SINGLES.

W. R. Reynell lost to A. D. Gardner... ...	4-6, 5-7
A. Traill beat W. W. Wagstaffe	6-1, 6-0
L. A. Graham beat R. C. Hewitt...	6-1, 6-3
R. Curle beat J. C. M. Harris	6-4, 6-4
N. Garrard beat J. A. D. Skinner ...	5-7, 6-3, 6-0
C. E. Petley beat C. J. Roberts... ...	3-6, 7-5, 6-2

DOUBLES.

Reynell and Traill beat Gardner and Wagstaffe	6-2, 6-2
Curle and Graham beat Hewitt and Harris	6-4, 6-2
Garrard and Petley beat Skinner and Roberts	6-3, 6-1



N. E. FASKEN,

Winner of the Featherweights, United-Hospitals Boxing, 1914.

The Athletic Sports.

The Athletic Sports were held on June 6th at Honor Oak Park. The dull and showery weather may be held partly responsible for the small attendance. The number of entries was poor, but the events were nevertheless keenly contested. Our chances of regaining the Athletic Shield cannot be good until the junior men display more enthusiasm in the sports.

Mrs. Hertz added much to the success of the afternoon both by the charm of her presence and by the gracious way in which she distributed the prizes. Results:—

100 YARDS SCRATCH.—K. F. McAlpin; C. L. Curle. Time, 10⅘ secs. Won by a yard.

100 YARDS HANDICAP.—K. F. McAlpin, 2 yards; G. Coutts Williamson, 5 yards. Won by a foot.

220 YARDS SCRATCH.—K. F. McAlpin; C. L. Curle. Time, 24⅗ secs. Won by 2 yards.

220 YARDS HANDICAP.—G. Coutts Williamson, 9 yards; K. F. McAlpin, scratch. Won by 2 feet.

440 YARDS SCRATCH.—C. L. Curle; E. S. Bowes. Time, 54⅘ secs. Won by inches.

440 YARDS HANDICAP.—G. Coutts Williamson, 30 yards; C. L. Curle, 10 yards. Won by 3 yards.

880 YARDS SCRATCH.—E. S. Bowes; H. Parry-Price. Won easily.

880 YARDS HANDICAP.—C. L. Curle; G. Coutts Williamson.

1 MILE SCRATCH.—E. Foulston; J. R. Barrow-Clough. Time, 4 min. 55 secs. Won by a foot.

1 MILE HANDICAP.—N. H. W. Saw, 30 yards; C. Lindsay, 50 yards. Won easily.

3 MILES SCRATCH.—G. Coutts Williamson; H. Parry-Price; N. H. W. Saw. Won by 5 yards.

3 MILES HANDICAP.—J. R. Barrow-Clough; E. Foulston; H. Parry-Price. Time, 17 min. 13 secs. Won by 3 yards.

LONG JUMP HANDICAP.—C. L. Curle, 1 ft., 21 ft.; C. H. Medlock, scratch, 20 ft.

LONG JUMP, SCRATCH.—C. L. Curle, 20 ft.; C. H. Medlock, 19 ft.

HIGH JUMP, SCRATCH.—C. L. Curle, 5 ft. 3 in.; C. H. Medlock.

HIGH JUMP HANDICAP.—C. L. Curle; C. H. Medlock.

PUTTING THE WEIGHT, HANDICAP AND SCRATCH.—F. W. Crook, 29 ft.; P. E. Grobbelaar, 27 ft. 5 in.

THROWING THE HAMMER, SCRATCH.—E. S. Bowes: M. B. Tweed.

THROWING THE HAMMER, HANDICAP.—A. W. A. Davies; M. B. Tweed.

DONKEY RACE.—K. Joffe; Mr. Higgens.

TUG OF WAR.—Won by 3rd year.

MEDICAL–DENTAL RELAY RACE.—Won by the Dentals. TEAM: C. L. Curle, G. Coutts Williamson, F. W. Crook, K. F. McAlpin.

LUCAS CHALLENGE CUP.—Won by C. L. Curle, 21 points. Runner-up, E. S. Bowes, 20 points.

Inter-Hospital Boxing.

This competition took place at the National Sporting Club on May 28th before a very large audience. Guy's tied with the London for the Shield, each Hospital obtaining 8 points. Both our representatives, N. E. Fasken and F. W. Stiven, were in excellent form. Fasken put up an excellent fight for the Feather-weights, and Stiven was exceptionally good in the Light-weights. The results were as follows:—

FEATHER WEIGHTS.—K. T. Limbery (St. Thomas's) beat J. P. Adcock (University); N. E. Fasken (Guy's) beat H. E. Griffiths (St. Bartholomew's). *Final bout*—Fasken beat Limbery.

HEAVY WEIGHTS.—Steadman (University) beat Lapage (Middlesex).

LIGHT WEIGHTS.—R. K. Shaw (St. Mary's) beat E. D. Granger (St. Thomas's); F. W. Stiven (Guy's) beat A. Grantham-Hill (London). *Final Bout*—Stiven beat Shaw.

WELTER WEIGHTS.—Coombes (London) beat Fagan (Middlesex).

MIDDLE WEIGHTS.—Chapman (London) beat Wayte (St. Thomas's).

Papers by Guy's Men.

R. Thompson, Ch.M., F.R.C.S.: An Operation for Undescended Testicle.—*Lancet*, May 30th, 1914.

R. Thompson, Ch.M., F.R.C.S.: Figures Relative to Congenital Abnormalities of the Upper Urinary Tract, and some points in the Surgical Anatomy of the Kidneys, Ureter, and Bladder.—*Journ. of Anat. and Physiol.*, April, 1914.

A. E. Boycott, D.M., F.R.S.: The Regulation of the Blood Volume in Normal and Nephritic Animals.—*Journ. of Pathol. and Bacteriol.*, April, 1914.

R. A. Chisolm, D.M.: The Regulation of the Blood Volume in Experimental Nephritis.—*Ibid.*

F. Gowland Hopkins, M.A., M.B., D.Sc., F.R.C.P., F.R.S.: The Oliver-Sharpey Lectures on Some Effects which follow upon Changes in the Reaction of the Blood.—Lecture I., *The Lancet*, June 6th, 1914; Lecture II., *The Lancet*, June 13th, 1914.

M. S. Pembrey, M.A., D.M., F.R.C.P.: Heat Stroke. Further Observations on an Analysis of Fifty Cases.—*Journ. Roy. Army Med. Corps*, June 1914.

C. H. Fagge, M.S., F.R.C.S.: Some Cases of Dyspepsia and their Surgical Treatment.—*Clinical Journal*, June 17th, 1914.

A. E. Maylard, M.B., B.S.: Cholecystotomy in lieu of Cholecystostomy in certain cases of Cholelithiasis.—*Brit. Med. Journ.*, June 6th, 1914.

E. G. Reeve, M.R.C.S., L.R.C.P.: The Treatment of Early Tuberculosis by Intensive Nascent Iodine.—*The Practitioner*, June, 1914.

E. Holman, L.D.S.: Common Difficulties of Every-day Practice, and some methods of overcoming them.—*Brit. Dent. Journ.*, June 1st, 1914.

E. D. R. Jacob, L.D.S.: Accurate Composition Impressions and Special Tray-making.—*Ibid.*

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

A Handbook for the Post-mortem Room. By Alexander G. Gibson. (Oxford Medical Publications.) Price 3s. 6d. net.

This is a handy little volume, comprising the information which is otherwise to be found in the opening chapters of textbooks of Practical Pathology. It makes no claim to be original, but it should form a valuable addition to the shelves of the general practitioner who, perhaps, is conscious of being rusty on the details of post-mortem technique and would like to be prepared for emergencies. It contains a chapter on the performance of autopsies in private houses, and on the restoration of the body, which should be useful to all those who would wish to allay the common prejudice against post-mortem examinations.

The fifth edition of Sir Patrick Manson's "Tropical Diseases," revised and enlarged, is announced for early publication by Messrs. Cassell & Company.

Births.

MEACHEN.—On May 16th, at 46, Petherton Road, Highbury, N., the wife of G. Norman Meachen, M.D., B.S., M.R.C.P., of 11, Devonshire Street, W., of a daughter (Grace Margaret).

SAUL.—At Pretoria, South Africa, on May 1st, 1914, the wife of A. L. Saul, M.R.C.S., L.R.C.P., L.D.S., of a daughter.

Marriages.

BRADNAM—STARMER.—On June 6th, at St. Mark's Church, Broadwater Down, Tunbridge Wells, by the Rev. Champneys, Vicar of Frant, Sussex, Cecil Hastings Bradnam, L.D.S., R.C.S. Eng., of Bexhill, younger son of Edwin Bradnam, Esq., J.P., of Hastings, to Helen Kate, younger daughter of G. H. Starmer, Esq., of Tunbridge Wells.

MARTIN—LEIGH.—On May 27th, at All Saint's Oystermouth, Glam., by the Rev. Canon Jones, M.A., Rector of Gellygaer, and the Rev. J. F. W. Leigh, M.A., Rector of Yorkhampton, Glos. (brother of the bride), assisted by the Rev. Harold S. Williams, Vicar of Oystermouth, Edward Graeme Martin, B.A. Cantab., M.R.C.S., L.R.C.P., son of H. W. Martin, J.P., of Sherwood, Cardiff, to Mabel Harriett Louisa, only daughter of Dr. W. W. Leigh, J.P., of Glyn Bargoed, Treharris, South Wales.

NEVILLE COX—GODDARD.—On June 17th, at St. Mary Magdalene's, Taunton, by the Rev. A. Allen Brockington, M.A., Vicar of Carhampton, Somerset, assisted by the Rev. S. Payne, M.A., Arthur Neville Cox, M.D. Lond., M.R.C.P., of Brighton, to Winifred Alice, youngest daughter of Mr. and Mrs. Goddard, of Apse, Taunton.

RIPPMANN—JACKS.—On May 27th, at St. Thomas's Church, Orchard Street, Christian Hugo Rippmann, M.A., M.D., M.R.C.P., of 77, Upper Berkeley Street, Portman Square, W., youngest son of the late Hugo Rippmann, to Freda Beatrice, younger daughter of the late Frederick W. Jacks.

Death.

YEOMAN.—On June 6th, 1914, after a long illness, Lottie M. Yeoman. Guy's Certificate, September, 1912.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 679.] JULY 4, 1914. [SIXPENCE.

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Passim.

MANY of our readers will hear with very real regret that Sir Cooper Perry has resigned his post as Physician to the Hospital. He has not, however, severed his connection with either the administrative or the clinical sides of the hospital, as he is still Superintendent and Physician to the Skin Department. Sir Cooper Perry is not due to retire under the age limit for two or three years yet, but his duties as Superintendent demand more and more of his time. The loss to the Hospital and School is, therefore, only partial, but it is very severe nevertheless. There is no one on the Staff to take his place as a teacher of purely clinical medicine, or as a demonstrator of morbid anatomy. It is some consolation, however, that the Skin Clinic on Tuesday afternoons will give him the opportunity of demonstrating to his audience the importance of careful observation, and of delighting them with his witty aphorisms, apropos of patients and their diseases. There was no formal "last round."

As a result of Sir Cooper Perry's retirement, Dr. Beddard has been promoted to full Physician, and Dr. E. P. Poulton has been appointed fifth Assistant Physician. Dr. Poulton is a Rugby and Oxford man, and had a distinguished career at both places. At Rugby he gained a Natural Science Exhibition and a Scholarship at Balliol. Whilst up at Oxford he took Chemistry Schools. He came up to Guy's in 1907, dressed to Mr. Symonds, and was House-Physician to Dr. Hale-White in 1911. In this year he passed his M.R.C.P. examination whilst still a Resident, won the Treasurer's Gold Medal for Clinical Medicine, and was made Radcliffe Travelling Fellow. He was appointed Demonstrator of Physiology in 1912, and Medical Registrar in 1913. He has published several papers on Metabolism and on Respiration, and is, in fact, a representative of the school of scientific physicians. We congratulate him heartily on his latest success.

WE publish elsewhere in this issue the list of Junior Staff Appointments. On the Medical side, Mr. J. A. Ryle (H.P. to Dr. Fawcett, February to July, 1914) is made Registrar in place of Dr. Poulton promoted to the Staff. On the Surgical side a re-arrangement of duties has taken place, and instead of having two Registrars, and two Junior Demonstrators of Anatomy, the four posts have been combined, and there will in future be four Registrar-Demonstrators. Messrs. A. H. Todd, G. T. Mullally, E. G. Schlesinger (H.S. to Sir Arbuthnot Lane, July, 1912, to January, 1913), and R. C. Ozanne (H.S. to Sir A. Fripp, November, 1913, to April, 1914), are the holders of the new appointments. Messrs. Schlesinger and Ozanne are newcomers on the Junior Staff. Mr. T. B. Layton, who has been Senior Demonstrator of Anatomy, as well as Throat

and Ear Surgeon, since 1911, has left the Dissecting Room altogether, and Mr. L. Bromley becomes Senior in his place.

We tender our hearty congratulations to all. At the same time we would express our regret at the impending departure of Mr. H. Gardiner, and wish him every success in whatever work he may be about to take up.

As a corollary to the allotment of beds to the Assistant Physicians, a new clinical appointment has been created—that of Assistant Physician's Clerk. Two clerks are appointed to each physician, and they hold office for three months. The applicant for the post must have been an ordinary medical ward clerk to a full physician for at least three months. His duties will be, in the main, those of a medical ward clerk or clinical assistant, but in addition he will attend his physician at Out-Patients on one day a week.

This addition of out-patient duty to the ordinary routine of medical ward clerk should make the appointment a very valuable one. As we pointed out a few weeks ago, the tendency is to correlate, as far as possible, the out-patient and the ward treatment of patients, so that a definite and continued scheme of treatment can be undertaken. It was largely with the object of bringing this about that the Assistant Physicians were given beds, and that the regulations providing that as far as possible out-patients shall be admitted only under their own Physician or the corresponding full Physician were made. The Assistant Physician's Clerk will have the opportunity, therefore, of following for at least three months the progress of all the cases sent in from his out-patients, and their further career after discharge from the wards.

This may seem at first sight a small matter, and one scarcely worth laying stress upon, but we feel sure that men in wards know less about the subsequent fate of in-patients than about any other aspect of their work. They have, no doubt, some vague memories and impressions as the result of reading the sections on Prognosis in their text-books, but they have scarcely ever followed their patients after they have left the ward. As a matter of fact the subsequent course of a patient is very often far more interesting and important than anything learnt during his stay in hospital. For instance, the demonstration of a gastric ulcer on the operating table, and the performance of a gastro-enterostomy for its relief are very interesting to watch, but the important point is how much benefit the patient is going to receive. This, of course, can only be determined by enquiry weeks or months afterwards in the out-patient room.

In reality, we believe, the best out-patients are the old ones, and we deprecate strongly the current fashion which makes men leave Out-Patients immediately the last new case is seen. Probably the best way to attend Out-Patients is always to go on the same day, and always to see the old cases. In this way one can trace the history of cases first seen as a ward-clerk for months, or even years, and so obtain a clear picture of at least one example of any given disease. One case fully observed is worth whole months of reading.

As we have already stated the Annual Garden Party will be held on Thursday, July 9th, at 3 p.m. Sir George Reid, High Commissioner for the Commonwealth of Australia, has consented to distribute the prizes. It is very appropriate that a distinguished Colonial should officiate at this function, in view of the very large number of men, both past and present, from the Over-Seas Dominions who are Guy's men, and the very big proportion of prizes and medals which they have carried off. We hope that Sir George Reid's presence will stimulate still the interest of Colonials in the Hospital, and cause an even larger number of them to come over for their medical training.

We have to congratulate Mr. C. de W. Gibb on gaining the Treasurer's Gold Medal for Clinical Medicine, and Mr. C. S. L. Roberts on gaining the similar medal for Clinical Surgery. Our congratulations are also due to Mr. A. E. Lowein on obtaining the prize for Operative Dental Surgery, and to W. G. Hollands, who has been awarded a certificate of the same examination.

WE hear with pleasure that Dr. J. G. Porter Phillips has been appointed Resident Physician at Bethlem Royal Hospital, and Mr. P. P. Cole elected Assistant Surgeon to the Cancer Hospital, Fulham Road.

ALL good wishes to Mr. L. Bromley on his marriage, which took place on Thursday, July 2nd.

Ralph Wingent Memorial Fund.

SEVENTH LIST OF SUBSCRIPTIONS.

	£	s.	d.
Malcolm E. Ball, Emsworth, Hants	0	10	6
M. R. Dobson, Ilkley, Yorkshire	1	1	0
Claude Marshall, Uganda Medical Service, Entebbe, Uganda	1	1	0
Horace Steinbach, Knaresborough, Harrogate, Yorks	0	10	6
S. Wilson	0	5	0
	3	8	0
Previously acknowledged (June 3rd, 1914) ...	31	13	6
Total	£35	1	6

H. C. MANN,
P. S. PRICE,
Hon. Secs.

July 1st, 1914.

Change of Address.

Maurice Craig, M.A., M.D., from 54, Welbeck Street, to 87, Harley Street, W. (Telephone, Mayfair 2686.)

A. S. Erulkar, M.B., B.S., from Guy's Hospital, to 21, Torrington Square, W.C.

W. J. O'Kane to Beanbah, 235, Macquarie Street, Sydney.

W. Adderley, Esq., L.D.S., to 12, Montague Place, Worthing.

Dr. A. G. Mossop, from 19, Wimborne Road, Bournemouth, to West Chase, Maldon, Essex.

Capt. H. C. Keates, I.M.S., to Multan, Punjab.

C. H. Stainer, Esq., from P.O., Lydenburg, to P.O. Box 116, Pilgrim's Rest, Transvaal, South Africa.

J. Wallace Kemp, M.R.C.S., L.R.C.P., from 40, Vereker Road, West Kensington, to 166, Coldharbour Lane, Brixton, S.W.

G. T. Foster-Smith, M.B., B.S., from 63, Shubra Road, Cairo, to c/o Messrs. G. Beyts & Co., Suez, Egypt.

Fighting a Delusion.

By FREDERIC VICARS.

I.

It was a raw November day in the Midlands. The country town of Slipton lay nestling in a valley between two ranges of low hills. A greyish mist hung over the houses like dirty gauze, encircling the chimneys with its damp embrace. In a small comfortable house at the corner of a street leading off the market place two men were engaged in conversation. A glance round the room would at once reveal that it was a doctor's consulting room. A large mahogany bookcase filled with books on medical subjects stood against one wall. A sofa across the curtained window had a light Eastern rug folded upon it. A worn black hearth-rug was stretched in front of the warm glowing fire, while a solid-looking writing-table occupied considerable space in the middle of the room. On the table lay a litter of papers, a pen tray, a collection of odds and ends, each connected in some way with the occupation of the man who, clad in a dark suit, sat in a revolving chair.

A tall rather thin figure, the brown hair turning grey, clean shaven, a firm set mouth, aquiline nose and a pair of dark keen eyes often called penetrating, long thin hands with the finger tips pressed together as they rested firmly on the blotting pad—such were the striking points of Dr. Norcross. Opposite him in an easy chair in an uneasy attitude was a man about 45, the same age probably as the doctor. He was a striking contrast to the other, with a pale, sallow face fringed with rather long dark lanky hair, a meagre moustache and beard, a straight nose, and dark melancholy eyes that told of sleepless nights and mental strain.

"You say I am sound in body, Doctor Norcross, sound as far as medical science can determine; yet, I am convinced that I am a doomed man, *a doomed man,*" he repeated, looking steadily before him.

"Well, that is a remarkable idea for you to have. Why do you think you are doomed, Mr. Marsh?"

"A strange thing happened to me a few days ago," began the other, speaking slowly and with some restraint. "I think I told you I am a literary man. I have been writing lately about Church Architecture. I have been here studying the Parish Church, which presents some rather novel Gothic irregularities. I was in the churchyard examining the West window on Tuesday last. Weary with straining my eyes looking at the beauties of the window, I rested my gaze on a nearer object. As I did so I was startled to see my own name and age upon a tombstone close by!

Sacred to the Memory of
GEOFFREY MARSH,
Who died November 30th, 1869,
Aged 45.

My exact age on the 30th of this month, the day after to-morrow."

"But really, Mr. Marsh," said the doctor, smiling, "this name on the tombstone is merely a coincidence."

"But the age, my age on the same day of the month, the day after to-morrow!"

"Pooh, also a mere coincidence."

The patient shook his head.

"I have inquired diligently of all sorts of people who this man was that died here thirty years ago, but no one seems to have heard of him. Even the Parish registers do not help me. The tombstone appears to be his only record."

He rose as he spoke and took a few steps in the room, his hands shaking as they moved through his lanky hair. Dr. Norcross watched him a moment before he spoke.

"You have been working too hard lately and your overwrought brain has conjured up a delusion. In many cases they spring from dwelling on what one calls coincidences. We doctors often have to treat people with overwrought brains. Come now, what shall we do for you?" he added, placing a sheet of notepaper on the blotting pad and picking up a pen.

"A prescription?" queried the other man.

"Yes, I think so, something that will restore balance to those tired nerves of yours."

Geoffrey Marsh shook his head.

"You will do no good with your drugs. I believe the day is about to come. The sign is out yonder." He pointed towards the window where beyond to the left lay the churchyard, a silent square, just off the main street.

The doctor got up from his chair, moved towards the fireplace, and, wheeling round, faced his patient.

"Do you really mean to tell me that it is your fixed idea that you will die on the thirtieth of this month?" He kept his eyes steadily on the twitching face of the man before him.

Bracing himself with an effort, the other replied doggedly: "*I do believe it.*"

Having delivered his answer he sank into a chair and buried his face in his hands. Neither spoke for a while. The doctor stood looking at the bent figure and appeared to be thinking deeply. Suddenly he roused himself.

"Mr. Marsh," he said, "you are staying at the 'White Hart,' I believe?"

"I am."

"Well, will you be my guest for a couple of days? I am a lonely bachelor; I shall be delighted with your company, and I think the change may do you good. Come now, say you will come to-morrow morning."

"You are very good," began the other, "but——"

"No, no excuse. Come, say you will."

"You are very kind—well, I would like ——"

"Right," replied the doctor, with energy, "it is agreed. To-morrow morning my man will bring your things across. In the meantime you will get this prescription made up at the chemist's up the street." He was writing on a sheet of notepaper as he talked.

Half an hour later the maid was getting ready the spare room which adjoined the doctor's bedroom, and by her master's orders she removed the key from the door between the two rooms, which she forthwith hung on a hook over the doctor's mantelpiece.

II.

The next day there was frost and mist, but the sun shone through the vapour and dispersed it by half past eleven.

Doctor Norcross returned from his morning round at one o'clock and found Geoffrey Marsh duly installed. He greeted him cheerily and made no allusion to the conversation of the previous day. Luncheon passed without any incident of note, and at three o'clock the doctor took his new patient with him on his second round, in a high dog-cart, with a steady mare between the shafts. At half-past four they returned to tea, and later the doctor suggested that Geoffrey Marsh would like to unpack his things.

Meanwhile some patients had to be seen in the Consulting Room. Just before seven the doctor went upstairs to his guest's bedroom.

"Don't dress, of course. I never do," said the doctor as he sat down in a chair. He kept up a running talk about the people of the neighbourhood and their doings or rather the lack of "doings," for Slipton was, as he said, a "dead and alive" place where life was one long dreary monotony. Still, even in the dullest place an eye for humour can generally find something of interest, and the doctor managed to keep his guest amused till the dinner bell rang.

"All right, I'll put out the light, I know my way in the dark," said the doctor; "you go ahead."

Before extinguishing the gas, Norcross looked quickly round the room.

"I don't suppose this fellow takes drugs. He leaves everything unlocked, I see."

A moment later he had joined his guest in the dining-room. The dinner was a success. The doctor was a bit of a gourmet, and Sarah, the cook, did justice to her reputation. With the dessert the doctor produced a bottle of '47 port.

"Several dozen in the cellar like that, sent me by an old patient who knew what port was, eh?"

"Delicious," was the reply.

"Do you a lot of good. Put new life into you."

The other man lifted his glass and said solemnly, "Let us drink for to-morrow ——"

"We'll drink again, my friend; aye, and the day after!"

"You think —" began the other man.

"*Think?* I know you'll be all right; so cheer up and drink another glass."

The wine flowed pretty freely, and as glass after glass of the celebrated vintage disappeared, Geoffrey

Marsh began to show signs of intoxication. Exuberant at first, he held forth on architecture, which discourse gradually merged into an attack on certain well-known architects whose opinions he dissented from.

"Call that—call that fellow an archi—tect? Rubbish—not fit to build a pigsty! Got contrac' for church at Burton other day—make awful mess of spire—bet what you like. As to that tower of his at Ealing, he—he—"

"Look here, old chap," said the doctor, rising, "it's getting rather late. What say you to bed?"

"Right ho!" He struggled up from the capacious armchair and stood unsteadily upon his legs. There was a placid smile of contentment upon his flushed face, and good humouredly he allowed the doctor to guide him to his bedroom and help him to undress.

"Thirsty?" asked Norcross as he signed to a syphon which he had brought up with him.

"Like a whale!" hiccoughed the other.

The soda water hissed into the tumbler and rapidly dissolved the white powder at the bottom.

"More, more," asked the other draining the glass at a draught.

Five minutes later his host bade him good-night as he turned out the gas and withdrew.

III.

The rays of the small shaded lamp came through the open door that led from the doctor's bedroom. Norcross slowly entered the room and stood a minute looking at the sleeping man. After listening intently to his heavy breathing, he took a few steps nearer the bed as if to satisfy himself that Geoffrey Marsh was fast asleep. He nodded his head by way of comment as he moved away and proceeded to search the room. He opened the portmanteaux on the floor and examined minutely their centents. Only clothes and articles of dress were to be found. A collar box was opened, but contained nothing. The collars lay on the dressing table. The bag on the chair was next put under scrutiny. Papers rustled softly between the doctor's fingers as he searched. Suddenly he plunged his hand deep down and touched a wooden box. Had he found something interesting at last? A mahogany case was soon brought to light and placed gently on the table. "Drugs or revolver?" queried Norcross. *Was it locked? No. There was a button catch at* one side which he pressed. Inside there was only a set of geometrical drawing instruments nestling in red velvet grooves. The doctor smiled, but steadily continued his search. Every piece of the luggage, every drawer, cupboard, nook, and corner in the room was examined, but no drug was discovered. Then he picked up the lamp and went again to the bed. The man lay unconscious; his deep breathing could be distinctly heard. The doctor gently put his finger on the wrist of the extended hand. The man did not move. Just then the booming tones of the church clock struck the hour of twelve. The thought passed through the doctor's mind as he looked at the sleeping man: "*The thirtieth day of November!*"

IV.

Eight o'clock on the morning of the thirtieth found the doctor at the bedside of his patient.

"Headache?" he asked, as he sat beside him while the latter rubbed his eyes in the process of awakening.

"I feel a bit muddled," he answered as he looked round. "Where an I? Oh, I remember, ye—es —" Then he relapsed into silence.

"Look here, Mr. Marsh," said the doctor, peremptorily, "you are going to get up, to have a bath, and then to have breakfast. Come along now. I am your director."

The strong man looked at the weak man, and the latter obeyed. The doctor left the room, but his presence in the house was manifested by a lively air which he sang as he walked about the next room and went up and down the stairs. Doors banged, the servants were called to and their voices responded. To Marsh, as he listened, a sense of life was perpetually manifested. As he thought, with feelings of misery, of his impending doom, there was the jar of noise and energy ever present. When he was nearly dressed the doctor came bustling into the room.

"Ha, ha," he laughed, "feel a bit chippy? Oh no, surely not after my '47 port? Well, the fresh air will soon pick you up. We'll go out in the cart at ten on my round."

At the appointed time the high dogcart was at the door and Dr. Norcross, with his patient, drove off. Behind sat the groom, who alighted at each stopping place and went to the horse's head till his master was again in his seat. It was a bright morning with a keen wind blowing. The hedgerows were covered with hoarfrost and the ground was hard.

The conversation was rather one-sided, for Geoffrey Marsh was moody and disinclined to talk. The doctor said he intended starting a motor car next year, for otherwise he would be considered out-of-date and out of reach of many of his patients, who were becoming demoralised by the new craze for speed. "They want you in ten minutes nowadays where formerly a good hour sufficed. The men from the big towns cut into our work terribly with their 20-h.p. cars."

"*More dangers by road now*," *jerked out the* gloomy man.

"Yes, indeed. In the old days an accident on the road was a rare occurrence. I remember ——" The doctor stopped speaking and looked keenly ahead.

The road before them ran straight and flat for about a hundred yards when it turned sharply to the left. A stone wall ran on either side, and it needed careful driving to pass another vehicle on the way. A noise of rumbling wheels could be heard like a cart being driven at a furious pace. In another moment a waggon without a driver came into view with the two horses galloping towards them. The doctor tried to

turn round, but the mare refused the rein and plunged forward. A collision seemed inevitable. With a great effort Norcross managed to guide the mare against the wall on the left, and then awaited events. Involuntarily the strange presentment of the man by his side flashed through his mind. He glanced at the poor fellow who sat still, rigid and pale, like one looking death in the face. A cloud of dust, a maddening rush, a sudden jar against the hub of the off wheel which shook the occupants of the cart violently, and the runaways had passed!

"To her head, James," shouted Norcross, pulling hard at the reins.

The groom flung himself down and rushed to the now prancing mare. As the animal quieted down, the doctor was able to attend to his patient, who had fainted.

"All right, Mr. Marsh, all right; buck up. Nothing's happened. Drink this," he added, pressing a flask to his lips.

"Thanks," he murmured as the colour returned to his lips, "I thought my time had come ——"

"Nonsense, man, you are all right now. Let's get home. The other cases can stand over till the afternoon."

In twenty minutes they were back again at the house, which they reached at one o'clock.

Luncheon was rather a depressing function, and a failure as a meal. It was all very well for the doctor to say Geoffrey Marsh must eat! He didn't. In spite of the rattle of talk which Norcross kept up, Geoffrey Marsh failed to respond to his efforts to cheer him. Between two and three, patients dropped in, and the moody man was left alone with the newspapers. Precisely at three o'clock the doctor burst into the morning room where Marsh was sitting, and cheerily proposed a walk.

"I have a few patients to see, and you can come along with me. You won't mind waiting while I drop in, will you?"

"Thank you, I should like to come."

Off they went together over the fields, the two men presenting a marked contrast: Norcross erect, walking with a firm, even tread and swinging gait; the other man rather bent and shuffling along with an irregular step.

(To be continued.)

Papers by Guy's Men.

A. Sandison, M.B., B.C.: A Case of Fibrosis of Lung Treated with Bacillus Friedländer Vaccine.—*Lancet*, June 27th, 1914.

F. Shufflebotham, M.D.: Abstracts of the Milroy Lectures on the Hygiene Aspect of the Coal-mining Industry in the United Kingdom. Lecture III. Mine Dust.—*Lancet*, June 27th, 1914.

Stanley Wickenden: A Case of Gall-stone causing Intestinal Obstruction.—*Lancet*, June 27th, 1914.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

The Swimming Bath.

DEAR SIR,—The warm weather which we have been enjoying lately makes one wish to have an occasional dip in the swimming bath. But on going to the College for towels, any time during the last two months or more, the invariable reply has been that "there are no towels, but it is hoped to have some by next week." In other years there have been towels, and if they are all worn out, surely the Students' Club, or whoever is responsible, could get some more, or else give notice that they do not intend to supply them any longer. It is easy to bring towels from home, but when told we can have them "next Monday," one waits till Monday, and finds no towels. ONE WHO WOULD BE CLEAN.

The Wills Library.

DEAR SIR,—Permit me to voice a grumble which has often been heard, but which never appears to reach the right place. *I refer to the chairs in the Wills Library.* With about three exceptions they all need re-seating very badly, and are most uncomfortable to sit upon.

If something could be done, it would be a blessing to those who have to work up for any examination and are not allowed to take the books out of the library. Possibly it is because the library is so uncomfortable that some books have not been returned at once, the borrowers having taken them outside to read in comfort.—Yours truly, TIRED TIM.

Pass List.

Society of Apothecaries of London.

The following candidates have been approved in the subjects indicated:—

Medicine.—*†A. J. Frädersdorff, *R. J. Hearn.

Forensic Medicine.—R. J. Hearn.

Midwifery.—A. J. Frädersdorff.

* Section I. † Section II.

Royal College of Surgeons, Edinburgh.

FINAL FELLOWSHIP.

Major Leonard Hirsch, I.M.S.

Reading "Without Spectacles," and the Treatment of "Short Sight."

CLINICAL LECTURE BY ARTHUR W. ORMOND.

GENTLEMEN,—On Friday, June 5th, the following letter appeared in *The Times* newspaper:—

READING "WITHOUT SPECTACLES."

TO THE EDITOR OF "THE TIMES."

SIR,—*The Times* this morning records the death of a workhouse inmate in her 102nd year, who possessed a remarkable memory "and could read without the aid of spectacles." The words which I have placed in quotation marks have become almost common form in any mention of the decease of an aged person; and, as they are never (or hardly ever) true, I would suggest that their use should be abandoned. After the age of about 50 no one who was not originally short-sighted can read ordinary print without spectacles; and, as short-sighted eyes are diseased eyes, their prospect of being still useful in advanced age is much smaller than that of eyes of normal construction. The customary paragraph would make every centenarian short-sighted, which is absurd.

I am, Sir, your obedient servant,

June 4. F.R.C.S.

This letter has given rise to considerable correspondence, and from June 5th to June 15th, letters on this subject appeared daily, creating quite an unrest amongst the laity who had had, or contemplated having, consultations with their ophthalmic surgeons. We are so accustomed to seeing our older relatives and friends arming themselves with spectacles, at first rather shamefacedly, and then later boldly and even aggressively, that we are apt to forget, or to overlook the fact, that this evil is evaded by some who live to even an advanced age.

The storm of indignation raised by this letter is easily accounted for when we read it critically. It states that it is never true, or hardly ever true, that anyone who can be described as aged can read without spectacles. It undoubtedly says this, but I am sure the writer did not mean it. Now, it is quite true that some people who have passed the allotted span of life of three score years and ten, can and do read for hours without the aid of glasses, as the writer of the letter was very soon informed by numerous correspondents during the following days. And the question whether this should be mentioned in the account of the decease of an aged person as an interesting item of news may be left to the judgment of the editor, but to me it is far more interesting, and tells me more about the deceased than many other statements to which "F.R.C.S." takes no exception. Now, the second half of the letter is written to qualify the first half, which is, as it stands, incorrect. The writer goes on to say, "After the age of 50 no one who was not originally short-sighted can read ordinary print without spectacles." If this had been inserted before the full-stop occurred it might have saved much trouble, and you, probably, from this particular clinical lecture! However, we are now much nearer the truth, and the statement that no normally sighted person at the age of 102 could read without spectacles, might have been passed as so nearly true as to be unworthy of dispute. I shall, however, show you later that exceptions to this rule are on record and capable of explanation. It is a fact that many of the people who do read small print after they are 70, without any aid from spectacles, are myopic.

You will notice another statement in this letter that may surprise you, "short-sighted eyes are diseased eyes." The term disease is indefinable. What is health? What is disease? What the writer means by diseased I do not know, but if he means more by the word than that short-sighted eyes do not conform to the arbitrary standard set up and designated emmetropia, and that they may become liable to certain diseased conditions, he is again incorrect. To tell a man who is 80 or 90 years old and whose eyes have fulfilled all his requirements, and who can still see to read small print and see his way about safely and easily, that his eyes are diseased, is, of course, to play with words. The number of patients who have one, two, or three diopters of simple myopia, and whose myopia does not progress, and whose fundus oculi show no signs of any pathological change, are not few, and to tell these patients when they reach 70 or 80 that they possess a couple of diseased eyes, would provoke the remark "that diseased eyes seem to be desirable things."

These statements about short-sighted eyes being diseased eyes all emanate from Germany and are quoted by English ophthalmologists as true in all cases, but experience teaches us that short-sight due solely and only to a slight displacement of the retina beyond the principal focus of the dioptric system of the eye and not in any way associated with pathological changes, is not very uncommon amongst well-to-do and educated English people, who do not of necessity use their eyes unduly.

"The selection of the proper glasses and the directions for their proper use are the first requisites for the treatment of ordinary myopia. This form of short-sight is a deviation from the normal, a fault in the construction of the eye although it does not exactly amount to a disease. To constitute a disease we must have the addition of disturbing changes in the eye which not infrequently constitute a source of danger."

"Disease is a purely definite conception and not identical with a deviation from the ideal normal."—(Hirschberg.)

Now we have it on record that Mrs. Peerybingle couldn't say "Which began it, the kettle or the cricket?" but in this instance undoubtedly the medical profession began it. "F.R.C.S." writes rather pathetically, later on, that he had no prevision that he was opening the door to so large a correspondence, but this virtue and excellence of reading or working without glasses when one is about 100 has been thought sufficient to immortalize some people, and in Hendon churchyard it is recorded on the tombstone of an old lady whose age was great —I forget the exact age—that she could see to read and sew without glasses; so you see the laity are very much impressed by it and know their facts, and it is unwise to generalize too much in the daily press on a subject which touches the ordinary reader.

The normal or emmetropic eye is one which is focussed for distant objects; all parallel rays of light passing through the pupil would come to a focus on the retina in an emmetropic eye. All "near" objects such as the letters of a printed page, are focussed by means of an arrangement within the eye, called the "accommodation." The "accommodation" is effected by means of the ciliary muscle and the lens. By its contraction the ciliary muscle relaxes the capsule of the lens and allows that body to assume a more spherical shape and so it becomes thicker antero-posteriorly and refracts or bends rays of light more sharply. This is the mechanism which fails us at or about 45, and we have to seek the aid of spectacles to assist this failing power. It is not then our *sight* at all which fails, but only our focussing power. If we use our focussing power for close work only, our distant vision will remain just as it was before we reached the presbyopic age, but if we were long-sighted or hypermetropic, then our distant vision having been dependent on our accommodation will also fail.

We must clearly grasp the conditions of sight present in myopia, and then we shall quickly understand that the myope is already focussed for near objects, even when his eyes are at rest and no accommodative action is taking place. If the myopia is equal to one diopter, the eye at rest is focussed for a distance of 40 inches, two diopters for a distance of 20 inches, three diopters for a distance of 13½ inches, but 13½ inches is a very comfortable distance at which to read, consequently a myope of three diopters never feels any particular need to wear glasses for the reading of ordinary print in a good light, and if he has four diopters of myopia, then he will never need glasses for reading at all.

But what about his distant vision? Take one of the letters in *The Times*, signed "T," published on June 10th. The writer makes a number of short statements: "I am 74 years of age. My sight has been normal all my life. I was never shortsighted. I have never had occasion to consult an oculist. I have never worn spectacles. I can read and write many hours a day with perfect ease and comfort. I have been a student all my life." The writer makes all these statements without any shadow of doubt as to their accuracy, and he may be quite right, but there is a doubt in my mind when, after reading "I was never short-sighted," I read: "I have never had occasion to consult an oculist." Now in testing vision we have a very arbitrary standard. If a patient can see certain sized letters at 20 feet distance we say that he is not short-sighted; if he cannot see them at 20 feet, but can at 19, we say that he is short-sighted. Of course this is quite arbitrary and for practical purposes these two individuals have equal sight. Nevertheless in classifying them they would have to go into different groups. Now as "T" has been a student all his life, he has never wanted his vision for the appreciation of fine differences at long distances, and his bare statement that he has normal sight is in my opinion unconvincing, especially as he has never had his vision properly tested.

At birth myopia is as rare as snow in harvest, the eyes are small and not fully developed; the eyes enlarge as the face enlarges, and the antero-posterior diameter of the eye is greater after adult life is reached than it is at birth, consequently another statement of "F.R.C.S." is explained: "No one can know whether he were born short-sighted or not, and that he must have been at least 30 years old before any precise measurement of the degree of short-sight was attempted." This statement is not very clearly put by "F.R.C.S.," but I think he means that

until the eye is fully matured, which he puts at the age of 30, myopia may develop even if not present, say, at 10 years or 15 years. This is quite true; many patients come at about 30 years of age to an oculist and say they notice that they cannot see as well in the distance as they did, and a small amount of myopia is found.

There is just one possibility that "T" is not shortsighted at all. I have known a case in which a patient had very small pin-hole pupils, and who had no certain myopia, and could read without glasses at 60. If you make a small clearly cut hole in a piece of thin card you will find that you can, when using one eye, read small print at a few inches from your nose, and when you remove the card you will have to increase the distance at which you can read the same print. This is a useful fact to know. The effect of a small "stop" is probably quite familiar to those of you who are photographers.

Another letter, signed W.B., is very interesting:—

GLASSES DISCARDED.

TO THE EDITOR OF "THE TIMES."

SIR,—Is my experience worth recording? Until two or three years ago I was almost entirely dependent on my spectacles, being quite at a loss if they were mislaid. Now I only need them for quite small print, such as that in the advertisements on page 52 in your issue of to-day. Normally I do all my reading and writing without their aid. At the same time I do not see faces or other objects at a distance so clearly. At the age of 78 I can only account for being thus able to discard spectacles by a considerable improvement in general health.

Your obedient servant,

June 8. W. B.

I hope W. B. will not see this clinical lecture; it is improbable that he ever should, but this phenomenon has been well known for some years. W. B. is becoming myopic, not owing to any elongation of his eye-ball, but to a change taking place in his lens. The refractive index is increasing, a change which sometimes precedes cataract. You notice he deplores some loss of his distance vision, so I suspect the clarity of his lens is already impaired.

SIR,—What nonsense they talk about the aged being unable to read without spectacles! In a few months I shall be 83 (D.V.) and I have never used any glasses to read. I was born moderately myops (No. 5) and use a glass in a picture gallery, but have always played cricket, tennis, and golf without any. My sight has never varied since boyhood. I can now, without any glasses, read any print—say, *The Times* debates in Parliament—even at night in a South-Eastern railway carriage. And I can write my name and address, date and place of birth, within the size of a sixpenny bit.

I am, &c.,

F. H.

SIR,—The interesting letters elicited by the dicta of "F.R.C.S." on the 5th inst. serve to remind us how untrustworthy are sweeping generalizations about personal conditions, even when made by learned "experts." I thought it worth while to offer you (under my initials on the 9th inst.) my own experience as it contradicts the rules laid down by so eminent an oculist as Mr. Brudenall Carter. He tells me that I could not know that I was myops in youth, as this cannot be ascertained until one is about 30. Now, as a fact my early short sight caused my parents to take me as a child, of four or five at most, to see a famous F.R.C S., in London. He examined my eyes and said, "Oh! he will do very well!" It was one of my earliest recollections. I could just stand up to the great man's knee. So from my earliest years I knew on authority that I was slightly short-sighted, but had sound and not "diseased" eyes.

As a boy I used a "monocle" to see distinct things, though I played games without glasses, and it was more habit than necessity. About 30 years ago, thinking that this might weaken the right eye by special use, I consulted a very great specialist in London, who told me it was blind!

I am certain that my eyesight has not varied at all for nearly 80 years. I can now read all the printers' type from "brilliant" to "double pica" equally well without any glasses, and even with my binocle, No. 5, if necessary. I use the binocle in a picture gallery, but drop it to read the catalogue. This is nothing uncommon, but is often found with other octogenarians. Beware of "experts" I say. Yours, &c.

Bath. FREDERIC HARRISON.

On the 9th June a very distinguished man joined in the controversy—no less a person than Mr. Frederic Harrison, and as becomes a positivist he writes with no little assurance. His first letter, which is entirely personal and within his own experience, is obviously accurate, but in his second letter he falls into the error of generalizing, although he states in the beginning of his letter that sweeping generalizations are untrustworthy. He makes several statements which are obviously incompatible. For instance, "I was born moderately myops. (No. 5)." "F.R.C.S." understands that to mean that he was born short-sighted to the degree of five diopters. "My sight has never varied since boyhood. In a few months I shall be 83, and I have never used any glasses to read. I can now read all the printer's type, from 'brilliant' to 'double pica,' equally well without any glasses, and even with my binocle No. 5, if necessary." He doth protest too much. If this is all true, why does he drop his glasses to read the catalogue if he can see as well with his full correction as without. If he can read "brilliant" with his No. 5 binocle then he is not fully corrected, and his short-sight has increased since his birth. That is the probable fact, as an increase in the amount of myopia is so frequently found amongst out-

patients that it almost amounts to a certainty. Another and even more interesting letter is the last one published, and signed "Monkswell."

TO THE EDITOR OF "THE TIMES."

SIR,—I have seen with interest the correspondence in your columns with regard to reading without spectacles.

Perhaps you will allow me, as one of those unhappy people who are never likely to want spectacles for this purpose, to call attention to what certainly seems the extraordinary failure of the oculists to devise a remedy other than spectacles for short sight.

The only difference between the eyes of a short-sighted person and those of a person with normal sight is a difference of shape, a difference so slight in many cases that the least pressure on the eyeball converts the short-sighted eye into an eye with normal vision. The problem is to make permanent this slight change of shape, and it is almost incredible that the immense resources of modern surgery should fail to solve this problem if a really serious attempt were made.

I write this as one bitterly aware through experience of the miseries of the short-sighted, and of the utter inadequacy as a cure of spectacles, which, besides being extremely inconvenient and ugly, distort the image of any object which is not looked at quite straight.

Your obedient servant,

MONKSWELL.

24, Buckingham Gate, S.W., June 12.

The last paragraph is a great exaggeration; if it were true that the majority of myopes found spectacles entirely inadequate, then the writer would not have to deplore the failure of surgery to solve the problem of a cure for short sight, because a method of cure has been elaborated and in a few instances carried out, but owing to the ease and safety and success of spectacles, it is very rare indeed for any patient voluntarily to prefer the risks of operative interference, and I want later to draw your attention to the various methods that have been suggested for the permanent alteration of the curvature of the cornea and the lessening of the antero-posterior axis of the eyeball. In the meantime with regard to the ordering of spectacles, Hirschberg recommends in young scholars who have a myopia between ·75 D. and 3 D., that they should use their full correction constantly - that is, for far and near. In medium degrees of short-sight between 3·5 D. and 6 D. full correction for distance and weaker (slightly weaker) for near work. In high grades, 6 D. and upwards, two separate pairs of glasses should invariably be given—the one for distance and the other, half its strength, for reading. My own custom has been different. In all cases of simple myopia in which no gross fundus changes are present, I try to get the patient to accept his full correction for far and near. By gross changes I mean vitreous opacities, lens opacities, myopic crescents with patches of choroidal atrophy on the outer side, rents in the choroid, hæmorrhages, etc.

If the patient cannot wear his full correction comfortably at first, I order a weaker lens to be used for a time and increase the strength gradually until the full correction is being worn. One rarely has any difficulty with children, and the advantages of wearing full correction are numerous. The visual acuity for distance is developed. The bad habit of holding everything close to the eyes and stooping over books, etc., is lessened. The eyes are placed as nearly as it is possible to do so in the condition of emmetropia. Next to heredity, the constant use of the eyes for small print or fine needlework is conducive to the development of short-sight, since by holding objects close to the eyes the convergence of the globes is maintained. Now convergence necessitates action by the internal recti and its opponent, the external rectus; between these two muscular bands the whole globe is compressed, with the result, that the antero-posterior axis of the globe is elongated. If we get our patients to wear their full correction, objects are held further from the eyes because things can be seen further away, and also the accommodative effort is lessened.

I would, however, at this point warn you that you must never, under any conditions over-correct a myope, and in many cases where patients have been unable to wear what has been thought to be their full correction, carefull examination has shown that they were over-corrected. I always examine a young myope by retinoscopy under full atropine in the first instance, so as to exclude any possible error in this direction. A patient having eight diopters of myopia would find a -9 sphere worn constantly quite intolerable; it would be no serious error to order a -7·5 sphere. Hence, as a practical point it is better to err by giving a slightly weaker glass than a slightly stronger one.

It has long been observed that after iridectomies and removal of cataracts, an artificial astigmatism is produced. The vision of a cataract patient is often very materially improved by a convex cylinder axis horizontal, after the acquired hypermetropia has been corrected by a sphere. Pflüger of Berne made use of this observation for the purpose of curing or lessening astigmatism. Section of the cornea was made at right angles to the meridian of greatest curvature. Considerable success follows this

procedure, but it is not permanent, as after months or years the effect diminishes and the astigmatism again becomes manifest; consequently the operation would have to be repeated probably many times. I have operated on a few cases, but I used the thermo-cautery in order to obtain a cicatricial scar, and so procure a flattening of the cornea, but I found the effect did not amount to any great alteration in the refraction, and after a time even this small amount disappeared. As a matter of fact the opportunity seldom arises for the performance of this operation, as most patients are quite satisfied with the results they obtain when wearing glasses.

In 1905, Mr. Maddox described a new operation for moderate short sight; the case was of a lad studying at Woolwich, and whose vision in one eye was just below the standard required by the Army regulations. He was extraordinarily keen to join the Army, and there were particular reasons why that career should be open to him.

Mr. Maddox made a large vertical incision through the margin of the conjunctiva, close to the cornea, and after that had healed, another horizontal one of a similar kind, below the cornea. The result was quite satisfactory, and the patient passed his medical examination a few months later. The risks of the operation are sepsis and prolapse of the iris, and as the incision must be a large one there is sometimes considerable difficulty in preventing the iris from leaving the anterior chamber.

For high degrees of myopia, Fukala's operation has been performed innumerable times. We at Guy's have had very satisfactory results, and I do not hesitate to advise it in suitable cases. It is only of use in high degrees of myopia, 16 diopters and upwards, if the visual acuity is not satisfactory when the full correction is worn, or if for any reason glasses cannot be worn.

The rationale of the operation is this: as to correct the high myopia a high concave lens is necessary, by removing from the interior of the eye the convex lens, we are able to discard glasses altogether or to use them only occasionally; that is, in some cases only for reading and in others only for distance. The pupil is dilated and the capsule broken, the aqueous then gradually dissolves the lens substance, and in course of time the lens disappears and the whole of the refracting power of the eye is done by the cornea and vitreous; consequently parallel rays of light entering the aphakic eye (*i.e.*, an eye without a lens) are refracted very little and come to a focus much further back, which is, of course, what is necessary in an elongated myopic eye.

It is usual to operate on one eye at first and if the patient is pleased with the result the other may also be treated in the same way; my experience is that the patient usually wants both done. Improvement in visual acuity, at least temporary, can be obtained in myopic eyes by massage of the eyes through the lids, by Domec's method. Lastly, enormous strides have been made by the opticians during late years in the grinding of lenses and *toric* lenses are now made in which the distortion of images due to prismatic effects is reduced to a minimum.

The writer of the last letter has certainly over-stated his case, but it is probable that he is not suffering from simple and uncomplicated short sight at all.

The Swimming Sports.

The sports were held at the Southwark Baths on Thursday, June 25th. The attendance of spectators was not as good as usual, but those who were present seemed to appreciate greatly the efforts of the competitors. All the events were well contested, and there seemed to be no lack of swimming talent at the Hospital. During the evening Miss Vera Neave, the famous swimmer, who is the champion long distance lady swimmer of the world, and the winner of the Richmond to Blackfriars swim of a few years ago, very kindly gave an exhibition of various styles of swimming, and Messrs Ede, Errington, Hughes, and Vingqrist, of the Amateur Diving Association, gave a magnificent display of fancy diving.

It was noticeable that the nurses both swam and dived much better this year than last. Nurse Loughman has not yet found a serious rival in either branch.

66 YARDS SCRATCH.—J. York Moore, 1; F. J. Ordish, 2. Time, 49 secs. This is York Moore's sixth consecutive victory in this event.

NURSES' 66 YARDS HANDICAP.—Heat 1, Nurse Yewdall (3 sec.), 1; Nurse Hook (1 sec.), 2. Heat 2. Nurse Loughman (scratch), 1; Nurse Tyler-Cove (7 sec.), 2. Final. Nurse Loughman, 1: Nurse Tyler-Cove, 2.

220 YARDS SCRATCH.—E. F. Llarena, 1; C. H. Laver, 2; R. Whelpton, 3.

BALLOON RACE.—W. A. Hawes.

NURSES' DIVING.—Nurse Loughman, 1; Nurse Sadler, 2.

66 YARDS HANDICAP.—A. Guinness (7 secs.), 1; J. T. Forbes (12 secs.), 2.

NEAT DIVING.—C. L. Curle, 1.

66 YARDS BREAST STROKE.—A. Guinness, 1; D. A. Bevis, 2.

TEAM RACE: MEDICALS (HOLDERS) *v.* DENTALS.—The Medicals won again this year. Teams.—Medicals: J. York Moore, C. G. Coombes, A. L. Anthony, R. Ralph.

Dentals:—C. H. Laver, F. J. Ordish, E. F. Llarena, R. Whelpton.

Obstacle Race.—J. York Moore, 1; E. F. Llarena, 2.

Water Polo Match: Guy's *v.* Mr. H. N. Eccles' Team.—Result: Guy's beaten 6 goals to 2. Teams.—Guy's: A. Guinness, F. J. Ordish, C. H. Laver, R. Whelpton, A. L. Anthony, J. York Moore, R. Ralph. Mr. Eccles' Team: H. N. Eccles, B. McB. Allen, Graham Marshall, F. Llarena, A. Goodman, A. St. John Styer, D. G. Pearce.

At the close of the proceedings Mrs. C. E. Iredell very kindly distributed the prizes to the successful competitors.

Nursing News.

The Royal National Pension Fund for Nurses.

The 27th Annual General Meeting of the above Fund was held on June 18th at the Royal Society of Arts, John St., Adelphi. The Chairman, Mr. Thomas Dewey, in moving the adoption of the report said that the past year had been highly satisfactory. The number of policies is almost the same as in 1912, but the premium income had increased by £400 per annum. The number of policies surrendered is less than in previous years. This reduction is possibly connected with the payment of benefits under the Insurance Act which enables nurses to overcome temporary difficulties without applying for a return of the premiums paid into the Fund. The invested funds increased from £1,720,475 to £1,819,318, an increase of £88,000. The income from these investments was £70,450. The annuitants in 1913 numbered 1,696, and the total amount they received was £44,000, or an average of £26 1s. 8d.

Dr. George Potter said there were 25,000 nurses who are paying to the National Insurance Fund, but who were not members of this Society. He suggested that if 25 meetings of 1,000 nurses each were convened, he would guarantee to convert 24,000 out of the 25,000 by simply telling them the facts of his twenty-five years' experience of the Fund.

All information respecting the Fund is supplied free of charge by post or on personal application to the Secretary, R.N.P.F.N., 15, Buckingham Street, Strand.

"Nursing Times" Lawn Tennis Challenge Cup.

The Guy's Team won easily their tie in the second round of this competition against the Southern Hospital, Dartford, on Tuesday, June 30th.

Nurses Ryan and Browning won their event 6-1, 6-2, 6-0

Nurses De Saram and Hayne won their event 6-2, 6-3

In the Third Round Guy's meet Shoreditch Infirmary.

University of London Officers' Training Corps.

Medical Unit. "B" Section.

A. March to Camp.

1. Leave has been given to any who wish to march to camp, leaving London on Friday, July 17th, and arriving at camp on Sunday, July 19th.

2. Cadets wishing to march down should give their names to Corporal Hamilton at St. Thomas's Hospital, or to Lance-Corporal McAlpin at Guy's Hospital, and hand to these N.C.O.'s three shillings towards expenses.

3. The marching party will assemble in Waterloo Station at the south end of the concourse at 1.45 p.m., on Friday, July 17th, to entrain at 2.10 p.m. for Reading. Dress-marching order.

4. Each cadet will bring with him sufficient food to last until 12 noon the next day, Saturday, July 18th, when the first ration will be served out. He will also bring knife, fork, and spoon in his haversack.

5. Cadets will bring their kit-bags, properly packed, to Waterloo, where they will be left to be brought down to camp by the main body on Saturday, July 18th.

B. Railway Tickets.

Tickets and vouchers will be given to cadets who do not travel to camp with the main body, the advance party, or the marching party, in accordance with the following regulations:—

1. Cadets travelling from or via London will be given on demand a railway ticket from London to Ludgershall.

2. Cadets travelling to camp from other places, at a distance not greater than that from London to Ludgershall, will be given on demand a free railway voucher.

3. Cadets (*a*) travelling to London to attend camp, or (*b*) travelling direct to camp, a distance greater than that from London to Ludgershall, will on demand be given a voucher, on production of which the railway companies will issue return tickets at single fares.

4. Cadets included under paragraph 3 (section *b*) will have refunded to them the amount payable by the contingent for a return fare from London to Ludgershall. Demands for this money to be made *in writing* to Headquarters *after the journey has been made.*

5. Cadets included under paragraph 3, who are at work away from their homes as a part of their educational course, or who can adduce other special reasons, may submit to Headquarters applications for free travelling vouchers.

6. Cadets included in paragraph 3 will not be given any grant in aid of travelling expenses, other than as provided in paragraphs 3, 4, and 5.

7. All demands for tickets or vouchers must be sent to reach Headquarters not later than July 14th. No ticket or voucher will be supplied, or money refunded, where application is not made by this date, except as provided for in paragraph 4. *No notice will be taken of any demands sent to Section Headquarters.*

8. Except in special circumstances, no grant will be made to cadets who proceed to camp by cycle.

T. B. LAYTON,
Lieut., R.A.M.C. (T.),
O.C. "B" Section.

Guy's Hospital, S.E.,
29th June, 1914.

Puppy
IT

"The Early Diagnosis of Tubercle."

THERE are, perhaps, few subjects of such great medical importance about which it is so difficult to gain real knowledge in hospital practice as the detection of tuberculosis in its incipient stages. Moreover, the literature on the question is difficult to obtain in a comprehensive and concise form. Apart from the more or less stereotyped paragraphs on the early signs of phthisis in standard text-books and the various articles in medical journals, written by enthusiasts for their own particular diagnostic methods, there are few, if any, moderately sized text-books to which a student can turn for a precise account of modern views on the subject.

The publication of the book on which this review is based* is, therefore, peculiarly welcome, the more so, moreover, in view of the concentrated attention which is now being paid to tuberculosis, and especially to the detection of the disease in its earliest and most favourable stage.

At the outset, therefore, we approach this book feeling that an attempt is being made to supply a real need, and the further our investigation of the work proceeds the more do we feel that the need has been adequately met. The author in his preface emphasises the limitation of his work to the *early* diagnosis of pulmonary and glandular tuberculosis. No space is wasted on descriptions of the clinical or post-mortem aspects of advanced or chronic tuberculosis, the object in view is always the study of the *incipient* aspects of the disease.

The importance of such a study is obvious, and it is certainly advisable at times to emphasise the difficulty of acquiring even a moderate degree of proficiency in this clinical art except by the most painstaking and constant practice. In Riviere's words: "The skill required for the early diagnosis of tubercle is, unfortunately, difficult and laborious to acquire, and no short cut to it does, or ever can exist—the path of experience must be duly trod."

The ordinary practice of a general hospital necessarily, perhaps, does not always bring this sufficiently to the fore. The average in-patient hospital case of phthisis is usually so obvious clinically that the student is apt to conclude that it is one of the easiest of diagnostic problems, whilst, on the other hand, the crowded condition of the Out-Patient Departments is not conducive to laborious investigation of every case of doubtful phthisis. As a result of this, there is but little doubt that the early signs of the disease are often unrecognised until the most hopeful period for treatment has passed by.

Riviere's book is divided into two unequal parts, about two-thirds being taken up with a discussion of pulmonary tuberculosis in adults, and the remaining third with the tuberculosis of thoracic glands in children.

The general plan of the book is indicated in the "Introduction." Riviere considers that the introduction of special and laboratory tests has, in many ways, impeded the art of diagnosis, and given excuse for careless and neglectful physical examination. This is, of course, no criticism of laboratory tests in themselves; it is simply a needed warning that they are not infallible, and that they can be readily over-estimated and misapplied. They are valuable servants, but dangerous masters. Again, it is of first importance to have a clear appreciation of, and acquaintance with, the physical signs of the *normal* chest and the *normal* reaction to various tests.

"How valuable seemed a febrile reaction to tuberculin—till it was demonstrated in 50 per cent. of the clinically sound! How striking are right apex phenomena, root-shadows on a skiagram, fever after exercise, and the like—till their existence as part of the varying norm is brought fully into view!"

Above all, skill is required in "assessing the relative value of the results obtained," and in considering the case as a whole without an undue or unbalanced estimate of single factors. Some are apt to think that the main problem in a doubtful case of phthisis is solved by the discovery of tubercle bacilli in the sputum, but, in truth, that is but a starting point from which we must proceed to the much more difficult and subtle task of estimating the activity of the disease; the probable prognosis and the appropriate treatment.

The practical clinician must, further, be prepared to make a diagnosis of phthisis apart from sputum examination, for it is the most insidious of diseases, presenting itself at first under such varied aspects as simple catarrh, influenza, neurasthenia, anæmia, dyspepsia, or general malaise.

In dealing with these so-called minor ailments it is difficult to avoid either, on the one hand, the fault of a merely symptomatic treatment, or, on the other, the fallacy of a diagnosis of tubercular mischief in every case of trivial disorder. It is only by careful and systematic physical examination that the truth can be ascertained. The presence of such simple conditions as we have mentioned enjoin upon the physician the need for further investigation, inquiry into family history, assessment of the general diathesis of the patient, and detailed study of his previous medical history. In doing this, Riviere rightly emphasises the importance of devoting the most careful attention to a history of *hæmoptysis* or *pleurisy*.

In regard to the former he says that a well-marked and authenticated hæmoptysis is, other causes being excluded, "well nigh pathognomonic of tubercle," so that in cases where there is no clear evidence that the hæmorrhage is not tubercular in origin, there is no doubt that phthisis should be presumed, and we agree with him in his statement that in such cases careful examination will usually show the physical signs of phthisis. An idiopathic pleurisy is also nearly always tubercular in origin, and Riviere's maxim that such cases should be kept under observation for at least five years is one which should be carefully borne in mind.

How is the all important physical examination best carried out? Riviere first describes in detail, with the aid of effective pencil sketches, the correct posture which the patient should adopt, a point of great importance, the guiding rule of which is to secure a pose of complete muscular relaxation. If the patient is allowed to tighten his muscles, either by holding up his clothes, or in other ways, deceptive physical signs will be produced, and correct diagnosis rendered even more difficult than usual.

In regard to percussion, Riviere takes up a strong and somewhat individual attitude. With the added

*The Early Diagnosis of Tubercle. By Clive Riviere. (Henry Frowde & Hodder & Stoughton, 1914.) 6s. net.

emphasis of heavy type he states that in his experience "some alteration to skilled percussion can be found over every diagnosable lesion." The word "skilled," however, begs the question, and renders the statement open to obvious criticism. Nevertheless, he produces good evidence of the value of percussion in the detection of early disease, and there is no doubt whatever that the careful practice of the art of percussion is a factor without which the early diagnosis of phthisis is made almost impossible. Above all, Riviere lays stress on the fundamental importance of *gentle* percussion, and in this he renders a notable service to those who wish to attain the skill he postulates. Gentle, as opposed to heavy percussion, is, unfortunately, much neglected by many clinicians. The results of Goldscheider, and others whom Riviere quotes, show that with gentle percussion disease has been detected in 25 per cent. more cases than with ordinary percussion, a result which none can afford to neglect. It is important, too, to remember that the extent of impairment to percussion is not in direct proportion to the extent of the lesion producing it, and several workers have shown that "a very small lesion may . . . . cause very considerable surface changes."

Percussion must be specially applied to the "seats of election" in phthisis, and these are fully described with diagrams, and a detailed account is given of Goldscheider's and Krönig's methods for percussing out the lung apices. Both these methods are complex and require considerable care and skill, but Riviere considers that in difficult cases the method of Krönig should always be systematically carried out. Riviere thus regards "skilled percussion" as an essential factor in diagnosis, and though in some respects he may seem to over-estimate its claims, it is, we think, an error on the right side, and if he is successful in drawing special attention to this somewhat neglected art, he will have rendered a real service to both patients and physicians.

Auscultation, the necessary accompaniment of percussion, Riviere regards as of almost equal importance, but he wisely lays stress upon its obvious difficulties, and especially the necessity for classifying and distinguishing the many sounds which the stethoscope reveals. The presence of definite adventitious sounds usually simplifies the diagnosis, but it is important to remember that it is on their persistent localisation to particular areas that a positive diagnosis can be made, and not merely on their presence alone. In their absence the breath sounds require detailed attention, and here Riviere points out the importance of adopting the method of "single-phase auscultation," whereby inspiration and expiration are separately compared, especial attention being devoted to the former. This is valuable advice which is not always sufficiently emphasised.

Turning to the question of differential diagnosis, a brief account, with illustrative cases, is given of the more important diseases and conditions which simulate phthisis, such as apical pulmonary collapse, due often to mouth-breathing, bronchiectasis, pulmonary œdema with mitral stenosis, chronic bronchitis, and asthma. The remarks on these conditions are both useful and interesting.

The value of X-rays in the diagnosis of phthisis is a much debated problem, and Riviere devotes considerable space to its discussion. Whilst wisely refusing to rank radiography with physical examination in point of accuracy or reliability, he does full justice to its claims. At the same time, we are glad to note that he points out its many fallacies, and the objection that the technique is beyond the reach of the average physician, with the consequent danger of reliance on the statements of those who are more mechanically than clinically expert.

Space forbids more than a passing reference to the section on Tuberculin in diagnosis, for in regard to this question Riviere gives so detailed and illuminating a discussion that we must refer those interested to the book itself, since paraphrase could only spoil its excellence. We would draw special attention, however, to the warning that subcutaneous tuberculin for diagnostic purposes should only be given by those who have had special experience in its use. This warning is much needed, for acquaintance with tuberculosis on a wide scale brings to light only too many instances of disaster resulting not only from inexpert therapeutic inoculation of tuberculin, but also from its diagnostic use.

The useful, but often neglected, diagnostic aid of temperature records before and after exercise is critically and usefully described, and a good account of the most recent bacteriological work on sputum examination, including the albumin reaction, is also given, thus concluding the section dealing with adult pulmonary tuberculosis.

In dealing with tuberculosis in children, attention is chiefly concentrated on the glands, especially those of the mediastinum. True pulmonary tuberculosis is rare amongst children, whereas some 80 to 90 per cent. of town children suffer from tubercular gland infection. Again, it is important to remember that between the ages of 3 and 15 the incidence of tubercular infection in children is very great, but the mortality comparatively negligible. In other words, the natural resistance to the toxins produced by tubercular gland infection is so great that it is usually very difficult to decide whether or not there is any definite lesion present, and whether it is active or latent.

These various points are emphasised by Riviere, and in regard to the question of diagnostic methods he places chief reliance on percussion and the X-rays. There are other important indications which must be noted first, however, such as fulness of the superficial veins, failure to gain weight, and, of course, enlargement of superficial glands. Slight enlargement of the cervical glands is so universal amongst children of the poorer classes that, by itself, it can carry little weight in diagnosis. In percussion the interscapsular region is of special importance, and Riviere emphasises the fact that it is not the enlarged thoracic glands that can be percussed out, but the impairment of note produced by their pressure interference with the surface communications of the lungs, arteries, veins, or bronchi. Partial collapse with surrounding compensatory emphysema is thus produced, and it is this which percussion and auscultation should reveal. To illustrate this, several cases are described, with appropriate diagrams, and a good case is made out for reliance on this mode of diagnosis.

X-rays are, however, in Riviere's opinion, the final court of appeal in regard to hilus tuberculosis, but attention is rightly directed to the necessity of a preliminary study of the normal X-ray appearances. Neither X-rays nor percussion, however, can give more than scanty information as to the activity of a tubercular focus, and it is on the general appearance, the

symptoms and history of the child that the question of treatment must largely be settled.

Tuberculin tests for diagnosis in children beyond the age of infancy are of only slight value. Only when a certainly negative result is obtained do we have evidence which is of importance. In such cases, however, the von Pirquet reaction is a valuable distinction between cases of slight bronchiectasis and tubercular infection.

The problems of early diagnosis of tuberculosis are thus equally difficult in children and adults. Constant experience is the only safe guide, but such cannot be obtained by all practitioners. To those, therefore, who desire to acquaint themselves with the most salient factors in early diagnosis which must be recognised and remembered alike by those who are constantly meeting with early cases, and by those to whom they come but rarely, we would heartily commend this concise and readable text-book.

ALEXANDER SANDISON.

Appointments.

The following appointments have been made, subject to confirmation by the House Committee:—

House-Physicians.—Messrs. E. D. Scott (Dr. Shaw); H. C. Rook (Dr. Fawcett).

House-Surgeons.—Messrs. C. H. Gould (Sir Arbuthnot Lane); W. H. Ogilvie (Mr. Dunn).

Out-Patient Officers.—Messrs. E. W. Blake, F. V. Bevan-Brown, A. B. Danby, C. Sherris.

Assistant House-Surgeons.—Messrs. W. E. Tanner (Mr. Fagge); C. F. Pedley (Mr. Rowlands); P. R. Boswell (Mr. Turner); C. S. L. Roberts (Mr. Hughes); J. Barrow-Clough (Mr. Davies-Colley).

Obstetric Resident.—Mr. J. F. Venables.

R.M.O. Bright Ward.—Mr. J. A. Edmond.

Clinical Assistants in Special Departments:—

Ophthalmic.—Mr. A. V. Moberly (Mr. Eason).

Throat and Ear.—Mr. A. Tilbury (Mr. Layton).

Vaccine.—Mr. S. Keith.

Genito-Urinary.—Mr. A. Tilbury.

July, 1914.

The following appointments and re-appointments in the Hospital and Medical School have been made by the Treasurer, subject in some instances to confirmation by the Court of Committees:—

HOSPITAL.

Resident Surgical Officer.—Mr. J. G. Saner.

Anæsthetists to the Hospital.—Messrs. Page, Shipway, Mullally, Ozanne.

Anæsthetist to Bright Ward.—Mr. Bromley.

Senior Assistant Bacteriologist.—Dr. Lucey.

Junior Assistant Bacteriologist.—Mr. Skene Keith.

MEDICAL SCHOOL.

Medical Registrars.—Dr. Mutch, Mr. Ryle.

Surgical Registrars and Demonstrators of Anatomy.—Messrs. Todd, Mullally, Ozanne, Schlesinger.

Ophthalmic Assistants.—Messrs. Ryley and Bookless.

Demonstrator of Operative Surgery.—Mr. Bromley.

Demonstrator of Physiology.—Dr. Kennaway.

Demonstrators of Chemistry.—Messrs. Merriman and Rogerson.

Demonstrator of Physics.—Mr. Abram.

Demonstrator of Biology.—Mr. Reed.

Douglas Demonstrator of Pathology.—Dr. G. W. Goodhart.

Civil.

G. H. Macalister, M.D., Pathologist, Imperial Bacteriological Laboratory, Muktesar, India.

Frank J. Tipper, L.D.S., to be Honorary Dental Surgeon to the Royal Portsmouth, Portsea, and Gosport Hospital

G. T. Foster-Smith, M.B., B.S., to be Medical Officer to the Anglo-Egyptian Oilfields and Chef du Post Quarantenaire de Gemsah, Egypt.

Royal College of Surgeons of England.

ELECTION OF EXAMINERS.

For Diploma in Public Health, Part II.: Sir Shirley F. Murphy.

For Diploma in Tropical Medicine.—Bacteriology: Dr. J. W. H. Eyre.

Indian Medical Service.

His Excellency the Governor of Bombay in Council is pleased to make the following appointment: Lieut.-Colonel L. F. Childe, M.D., I.M.S., on return to duty, to resume his appointment of First Physician, J. J. Hospital, and Professor of Medicine and Clinical Medicine and Therapeutics, Grant Medical College, Bombay, and to be Senior Medical Officer, J. J. Hospital, and Principal, Grant Medical College, Bombay.

Major V. P. Hutchinson, I.M.S., has been transferred from the Military Hospital at Pretoria to Potchefstroom.

Retirement.

Dr. Arthur Roper, of "Colby," Lewisham Hill, has retired, having been in practice in Lewisham fifty years. Dr. Roper is remaining in his house until he lets or sells it.

PAPERS, ETC., RECEIVED.—Hospital, Nursing Times, M.S. Journal, Middlesex Hospital Journal, St. Mary's Hospital Gazette, Clinical Journal, London Hospital Gazette, New York State Journal of Medicine.

Cricket.

INTER-HOSPITAL CUP (First Round).

GUY'S v. ST. BART.'S.

Played at Honor Oak on June 9th. Guy's won by two wickets.

ST. BART.'S.

E. G. Dingley, b Sampson	21
R. Maingot, c Coxon, b Sheldon	9
J. C. W. McBryan, lbw, b Sampson	0
S. R. Prall, b Sheldon	8
A. E. Parkes, c Biddle, b Dixon	56
T. Owen, c Vincent Brown, b Sheldon	5
R. H. Williams, b Dixon	1
H. J. Bowers, not out	8
J. S. Haynes, b Dixon	7
J. F. Juckes, c Sampson, b Biddle	5
L. Brawn, b Dixon	0
Extras	6
Total	126

GUY'S.

C. Vincent Brown, b Owen	19
A. C. M. Coxon, b Brawn	10
J. R. Cox, st Williams, b Bowers	37
L. H. Dixon, c Juckes, b Parkes	4
F. Biddle, c Williams, b Parkes	8
D. M. Whitcombe, b Juckes	3
B. Sampson, run out	0
W. T. Sheldon, not out	36
H. M. Gray, b Parkes	1
L. H. Gilbert, not out	0
C. G. Gibson, did not bat.	
Extras	9
Total (for 8 wickets)	127

GUY'S v. HAMPSTEAD.

Played at Hampstead on June 17th.

HAMPSTEAD.

A. R. Tanner, c Sheldon, b Dixon	5
J. G. Donaldson, b Sheldon	12
M. A. Sturt, c Sampson, b Gray	69
G. H. Beaton, b Sheldon	0
G. S. Hickson, not out	72
G. G. Dumbleton, lbw, b Gray	0
W. Preston, b Sampson	9
G. W. Orr, b Sampson	0
G. R. Trimen, lbw, b Sampson	0
J. C. Snaith, b Dixon	2
S. E. Hooper, b Sampson	1
Extras	17
Total	187

GUY'S.

T. W. Sheldon, c sub, b Tanner	5
C. Vincent Brown, c Trimen, b Tanner	23
L. H. Dixon, b Hooper	0
D. M. Whitcombe, b Hickson	21
B. Sampson, not out	29
H. M. Gray, c Trimen, b Dumbleton	2
L. H. Gilbert, b Hickson	0
D. Waight, st Beaton, b Sturt	6
C. C. Gibson, b Sturt	1
G. Peatfield, c Hickson, b Tanner	8
D. Dingley, lbw, b Tanner	0
Extras	15
Total	110

GUY'S v. BROMLEY.

Played at Honor Oak on Saturday, June 20th. Dixon batted splendidly for his 135. Sampson took 7 wickets for 103.

BROMLEY.

C. G. Hill, b Sampson	36
W. F. Thompson, b Dixon	65
B. H. Tucker, c Eglington, b Sampson	29
R. Montgomery, c Vincent Brown, b Sampson	24
E. W. Cooper, lbw, b Sampson	14
C. L. Gregory, not out	38
H. Thompson, b Sampson	14
L. A. Tucker, c Whitcombe, b Sampson	10
A. E. Earnshaw, did not bat.	
T. Marriot, did not bat.	
A. G. Bower, b Sampson	5
Extras	18
Total (for 8 wickets)	253

GUY'S.

C. Vincent Brown, b Tucker	19
L. H. Dixon, b Tucker	135
H. C. Rook, b Tucker	0
H. M. Gray, b Bower	4
D. M. Whitcombe, b Tucker	17
B. Sampson, b Bower	3
A. C. M. Coxon, b Tucker	7
H. Peregrine, c & b Bower	7
D. Eglington, b Tucker	0
R. V. Cookes, b Tucker	4
C. C. Gibson, not out	0
Extras	2
Total	198

INTER-HOSPITAL CUP (2ND ROUND).

GUY'S v. ST. MARY'S.

Played at Hale End on June 25th. Won by Guy's. L. H. Dixon was in great form with bat and ball. He hit splendidly for his 80, and took five wickets for 44.

ST. MARY'S.

V. C. W. Vickers, c Gilbert, b Sheldon	6
A. R. Moxey, b Dixon	1
P. W. Armstrong, b Dixon	5
D. C. Farquarson, b Dixon	3
R. M. Handfield-Jones, b Dixon	0
A. R. Fuller, lbw, b Sampson	32
T. Reason, c Gibson, b Dixon	17
C. L. Mason, c & b Sampson	10
K. M. Nelson, b Sampson	7
W. A. Date, c Whitcombe, b Sheldon	18
J. S. Lewis, not out	4
Extras	9
Total	112

GUY'S.

L. H. Dixon, b Reason	80
C. Vincent Brown, b Reason	38
W. T. Sheldon, not out	1
J. R. Cox, not out	6
Extras	15
Total (for 2 wickets)	140

D. M. Whitcombe, A. C. M. Coxon, C. C. Gibson, B. F. Sampson, L. H. Gilbert, H. M. Gray, Sterling-Hill (did not bat).

Births.

NASH.—On June 17th, at Turvey Grange, Beds., the wife of Lorimer Gifford Nash, M.R.C.S., of a son.

SMALLEY.—On May 25th, at Kowloon, Hong Kong, the wife of Jas. Thornton Smalley, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

ODGERS—HIGGINS.—On Tuesday, June 30th, at All Saints, Ennismore Gardens, by the Rev. W. E. Addis, M.A., Norman Blake Odgers, M.Ch., F.R.C.S., third son of the Rev. Dr. Odgers, of Oxford, to Mabel, youngest daughter of G. Randell Higgins, The Croft, Burcote-on-Thames, Oxon.

SOLOMON—SHARLAND.—On June 16th, at St. Michael's, Bournemouth, Edgar Eaton Solomon, L.D.S., to Margaret Mary, eldest daughter of the late Wm. Claridge Sharland and Mrs. Sharland, of Bournemouth.

Death.

LOVEGROVE.—On April 23rd, at Thirroul, New South Wales, James Francis Lovegrove, M.R.C.S., L.S.A., aged 78 years.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Garden Party and Distribution of Prizes was held on Thursday, July 9th. A full report of the speeches will be found elsewhere in this issue. The weather was ideal—in fact it was almost too hot—and the Park looked at its best. There was an immense concourse of guests, and with all the light summer dresses of the ladies, and the gorgeous robes of many of the males, the scene in the Park was very gay. The various Departments of the Hospital and School and the Nurses' Home were open for inspection, and our sisters and cousins were as usual pleasantly horrified by the Museum and the Operating Theatres. A display of needlework by members of the Guy's Hospital Ladies' Association was shown in the Nurses' Home, and appeared to greatly interest those who understand such things. Tea was served in the Colonnade and in the Park, and the familiar struggle took place around the tables. The Royal Meister Orchestra provided excellent music as in previous years.

The Dean in his Annual Report again returns to the need for further endowment of research work. The funds of the Hospital itself are not, of course, available for this work, as they are all urgently needed for the immediate relief of patients, and the income of the Medical School is barely sufficient, as it is, for the purposes of routine instruction. At the same time there is an urgent need for further research work in all departments of Medicine and Surgery, and the only way by which the best men can be retained for this work is to provide them with funds for the carrying out of their work and the wherewithal to live meanwhile. This money can only be provided by endowment, and this endowment is more valuable if associated with a medical school and hospital than if it is applied in a special research institute. Very much good work has been done and will continue to be done at these special institutes, but there is too great a tendency for the research to become fixed in a narrow academic groove and so develop along lines of little practical importance. In a big teaching hospital this danger is considerably lessened since the men engaged in research work are constantly in contact with their colleagues engaged in practical medicine and therefore are more likely to preserve a wide perspective.

In order to encourage this mingling of the scientific and clinical sides of medicine, and to co-ordinate their work, a committee of representatives of both branches has been formed in the School. This committee will be of value in enabling investigators to find the class of cases they require, and will tend to prevent too much over-lapping of research in the different departments. But its sphere of usefulness will be very small until further endowments increase considerably the number of workers in this field.

THE Biennial Festival for 1914 was held in the Connaught Rooms on Friday, July 3rd. The attendance did not constitute a record, but

it was quite up to the average, almost 300 old Guy's men being present. It was, as from its nature it always will be, a great success. There were, according to recent custom, no speeches, the toasts being proposed without further elaboration. After the usual loyal toasts had been proposed by the Chairman, Lord Goschen proposed the health of the Chairman, Sir Cooper Perry. This toast was the occasion for a tremendous ovation, clearly demonstrating how high a place the "Super" occupies in the affections of all Guy's men. The toast of Guy's Hospital and Medical School was also received, as is only natural, with great enthusiasm.

After this, the more formal part of the evening's proceedings, the diners scattered themselves over the hall seeking out those of their old friends who were not sitting close to them. This was the most enjoyable part of the evening, both to take part in and to watch. The old men often say how much they appreciate the sight of youngsters enjoying themselves, but after this Dinner the youngsters can reciprocate the compliment. It is worth being young to see portly middle-aged old gentlemen slap one another on the back, and to see them respond to a nick-name just as foolish or wise as any we use to-day. We are sure that after he had made the tour of the tables no one was sorry he had come. On all sides it was the same story—"Hallo, what are you doing now—I haven't seen you for years—Do you remember, etc., etc." There was, however, one regret heard constantly during the evening, "Why didn't old So-and-So turn up? I was looking forward to seeing him to-night." The men who do not come to the Dinner not only miss a very pleasant evening for themselves, but also deprive their old friends of much pleasure.

The arrangements for the Dinner were very excellent, and the places at the tables were arranged to suit, as far as possible, everyone's convenience. We did not at any rate hear any grumbles on that score.

The Programme was embellished with a very excellent cartoon of the Chairman, from Mr. Stanley Cock's talented pen.

THE Clinical Congress of Surgeons of North America are holding their Fifth Annual Session in London this year, from July 27th to August 31st. The work of this Congress is entirely concerned with clinical matters, and aspects of surgery outside the clinical one will not be dealt with. From 9 a.m. to 5.30 p.m. on each day of the week, special operative clinics and demonstrations will be given by the London surgeons, and every phase of surgical practice, both general and special, will be presented. In the evenings, papers on surgical problems of present day interest will be read and discussed by the leaders of American and English Surgery.

The Guy's surgeons are, of course, doing their share in holding clinics and demonstrations for the visitors, of whom about 1,500 are expected. Almost all the surgeons are operating on one or more days during the Congress, and in addition several series of cases showing the results of various methods of treatment are to be shown. No doubt our visitors will be particularly interested in Sir Arbuthnot Lane's work, and his theatre will be overcrowded every day as was the case during the International Congress of Medicine last year.

THIS idea of meetings devoted entirely to clinical work originated in America and has developed widely in that country. The scheme has even spread to this country, and the surgical-at-homes which were held in London last year and again this year are evidence that the new spirit is taking hold over here. There can be no two opinions as to its value. Our powers of appreciating the significance of written words are so poor that no description of technique, however careful and however clear, is ever one half so valuable as the actual seeing of the same proceeding even under the worst conditions. We read an account of a particular line of treatment by the originator of the method, but we in reality are very little the wiser afterwards. In the first place we are not clear as to exactly what type of case is considered suitable, we cannot visualise the procedures employed sufficiently well to know quite what is done, and above all we do not know what in the writer's opinion is a good result. Of course,

to learn all this thoroughly would require weeks of observation; but, nevertheless, half an hour's observation is of more value than hours of reading. Perhaps in time to come we will all be so well educated that we shall understand clearly what is the full meaning underlying a page of printed symbols. Most of us, however, are very far from that stage, and our visuo-psychic areas are more accurate than our "word-seeing" areas.

This scheme of personal observation is capable of great extension quite apart from formal congresses and from visits to clinics on the Continent and in America, and is applicable to others besides surgeons. Physicians would find much of value in the teachings of their contemporaries which they cannot get from their writings if they held demonstrations on suitable cases from time to time, and even the busy practitioner would be no loser by occasionally going round with some eminent teacher in any branch of his work. We look forward greatly to the time when it is the custom for recently qualified men to visit in turn most of the other metropolitan hospitals and some at least of the provincial ones. The gain both to the individuals visiting and to the visited will be very great, and will, by raising the standard of teacher and of pupil, therefore increase the efficiency of the profession as a whole.

We have to congratulate Dr. E. L. Kennaway on being appointed to a post in the new Institute of Chemical Pathology at the Middlesex Hospital. Dr. Kennaway is a Middlesex man, and so returns to familiar scenes. He came to Guy's in 1909, and has been Demonstrator of Physiology since that year. We wish him every success in his new work, but at the same time we feel that the School is sustaining a great loss in Dr. Kennaway's departure. He will be very difficult to replace as a teacher of physiology—he has the gift of being able to make the most obscure parts of the subject clear even to the dull men. All who know him will regret the departure of a very able teacher, and of a charming colleague.

Our contemporary, *South Africa*, has devoted considerable space in its issue for this week to an account of the very large colony of South Africans now at Guy's—there are, we understand, about fifty of them—and to the numerous successes, both academic and athletic, that they have gained here in recent years.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Acute General Miliary Tuberculosis. By Professor Dr. G. Cornet; translated by F. S. Tinker. (John Bale, Sons, and Danielsson, Ltd., London.) 6s. net.

This is a thoroughly comprehensive monograph on miliary tuberculosis. The ætiology is fully discussed and the opposing views compared with creditable impartiality and sound judgment. The author considers the vascular theory of Weigert as presenting the most probable explanation of the facts of the disease, and deals critically with the objections of Ribbert and others who maintain that vein tubercles are only rarely concerned in the origin of miliary tuberculosis. The question whether tubercle bacilli can multiply in the blood or not is treated with insight, and an interesting and convincing account is given of the origin of vascular tuberculosis. The importance of thoracic duct tuberculosis is also emphasised, and credit given to Astley Cooper for its identification in 1798. The relation of phthisis to general miliary tuberculosis is further discussed, and the predisposing factors in the anatomy of children, whereby the dissemination of miliary tubercles is favoured, are described in full. The section on pathological anatomy is thorough, and a clear account is given of the symptoms, course, and clinical picture of the disease. In regard to the often difficult differential diagnosis from typhoid fever there is a valuable discussion, and the author further lays stress on his conviction that acute general miliary tuberculosis is not inevitably fatal, and that its therapy is not necessarily purely symptomatic, although he admits it is usually a very thankless task. Mention must also be made of the extensive and typically German bibliography which extends to 11 pages, and comprises a tenth of the whole book. Useful as it is, we are saddened to notice only two references to English authors, one of these being to Astley Cooper as mentioned above. Finally, the translator is to be complimented on having produced a most readable version of the original.

The Distribution of Prizes.

THE Distribution of Prizes took place at the Hospital on Thursday, July 9th, 1914, under the presidency of Viscount Goschen, the Treasurer. The company present included the Governors of the Hospital and members of the consulting medical and surgical staff, physicians and surgeons of the active staff, and the Mayors of Bermondsey and Southwark, Sir Robert and Lady Nivison, Colonel F. A. Lucas, Deputy and Sheriff Sir Frederic and Lady Painter, and the Masters of the Worshipful Companies respectively of Leathersellers, Girdlers, and Carpenters.

Among the Colonial guests were Sir Robert and Lady Hadfield, Professor MacLennan, Mr. Randal Woodhouse, Mrs. Carmichael, Mr. F. W. Haybittle, Mr. and Mrs. Denham Pinnock, Mr. and Mrs. R. H. Nolan, Dr. Herschel Harris, and Dr. W. R. Ayson.

Immediately on assembling in the new School Buildings, the Chairman called upon the Dean of the School (Dr. H. C. Cameron) to read the annual report of the Medical and Dental Schools :—

THE DEAN'S REPORT.

Two years have elapsed since the Dean of the Medical School presented his Report upon an occasion such as this. In June of last year Mr. Balfour, a Governor of the Hospital, visited the School and formally declared its new buildings open. The importance of that occasion in the history of the School, marking as it did the completion of a great and sustained effort of re-construction, was emphasised by a special ceremony, and the Annual Prize-giving was postponed until the opening of the new Session in October, when a full report of the numerous changes consequent upon the extension of the School was presented.

Since that date sufficient time has elapsed to make clear the great benefits which the School derives from the increased accommodation at its disposal. In the new Laboratories of Chemistry and Physics the results, as shown by the Pass Lists of the various Examining Bodies, have been extremely good ; while the provision of well-equipped Departments of Pathology and Pharmacology has enabled the School to provide adequate instruction in a group of Subjects intermediate between the earlier studies of Anatomy and Physiology and the Final Subjects of the curriculum.

The increased accommodation has also made it possible for the School to give a larger share of attention to the instruction of Post-Graduate Students, and Special Courses, instituted to meet their needs, have been well attended.

During the year, 35 Students have passed the Final Examination for their Degree at the Universities : 6 at the University of Oxford, 5 at the University of Cambridge, 19 at the University of London, and 5 at the University of Durham ; 48 Students have obtained the Conjoint Diploma granted by the Royal Colleges of Physicians and Surgeons. In addition, 6 Students have taken the Degree of Doctor of Medicine, and 3 the Degree of Master in Surgery ; while 11 have passed the Final Examination for the Fellowship of the Royal College of Surgeons of England.

Throughout the whole of the Dental Department increased order and efficiency testify to the wisdom of the School in appointing a Resident Dental Officer to devote almost his whole time to the executive work of the Department. During the year, 43 Students have obtained the Licence in Dental Surgery of the Royal College of Surgeons of England, and the percentage of successes in this examination has been remarkably high.

Changes in the School Staff have not been numerous. The School has, however, to deplore the retirement of Sir Cooper Perry from his post of Lecturer in Medicine and Physician in Charge of In-Patients in the Hospital. The great services which Sir Cooper Perry has rendered to the School in all matters of administration and reform have never obscured his success as a Teacher of Clinical Medicine and of Morbid Anatomy in particular. His colleagues in the School may take this opportunity of expressing their appreciation of the motives which have led him, against his own inclination, to withdraw from a post which he has long held with conspicuous success solely that he may have more leisure to serve Guy's in other ways. Sir Cooper Perry still remains in active charge of the Department for Diseases of the Skin, and the School will continue to have the benefit of his teaching in that Subject.

Dr. A. P. Beddard succeeds to the Lectureship in Medicine, and to the charge of the beds vacated by Sir Cooper Perry, while Dr. E. P. Poulton has been appointed Fifth Assistant Physician.

We have also to record the resignation of Dr. Assheton, who for many years held the post of Lecturer in Biology in the School. Dr. Assheton's great knowledge of Embryology, and the high position which he holds in Science, reflected distinction upon the School, which deeply regrets his loss. To fill the post the Treasurer has appointed Mr. T. J. Evans, of the University of Sheffield. To Dr. Assheton, to Dr. Lowry, the Lecturer on Chemistry in the School, and to Dr. Boycott, till lately Gordon Lecturer in Pathology, the School extends its hearty congratulations upon their election to the Fellowship of the Royal Society.

Finally, Mr. H. P. Aubrey has found himself compelled to resign the post of Assistant Dental Surgeon, which he had held since 1911, and Mr. H. C. Malleson has been appointed to take his place.

In the increased facilities for investigation and research, the benefits conferred by the new buildings are especially apparent. The number of those whose whole

time is given to teaching and scientific investigation has of late years rapidly increased, and in the Medical School alone there are now 30 workers permanently engaged in research, besides Members of the Hospital Staff. Under the Chairmanship of Sir Cooper Perry a Committee consisting of the Heads of the several Departments of the School, and representatives of the Hospital Staff, has been formed to co-ordinate the various investigations which are being carried on simultaneously, and to give all possible facilities to the workers in the collection of material. By the desire of the School this Committee has been given the control of the Medical School Research Fund. This Fund, which was started many years ago by a gift of £1,000 by the late Mr. Pierpont Morgan, is the sole source from which investigators are able to obtain grants for the purchase of costly apparatus, and is, unfortunately, all too small for the present demands upon it. The work of this Committee has already borne fruit in the establishment of a small Ward for the study of Diseases of Nutrition in Infancy, in which investigations are being carried out both clinically, and in the Departments of Physiology, Bacteriology, and Chemical Pathology. Work has also been started upon the erection of a new block of laboratories, situated in the immediate neighbourhood of the Medical Wards, and designed to afford ample accommodation for the Physicians and Assistant Physicians to the Hospital, and those working under their direction.

In the Dental Department, the School has to acknowledge the generous aid of an anonymous friend, who has undertaken to bear the whole cost of an extensive research now being carried on in the Department of Dental Metallurgy by a specially appointed Research Scholar.

With greatly increased activity in all Departments of the School, the Staff has to consider earnestly the difficulty of securing adequate financial support. The income of the Medical School, as distinct from the Dental School, derived from Students' fees, is approximately £11,000 per annum, and it is obvious that this must be rigidly devoted to purposes of instruction rather than of research. The income of the great Hospital which the School serves must remain untouched, expended entirely on the relief of the sick poor and not upon the study of the nature of disease or its prevention. It is gratifying to be able to state that although the present time is fraught with danger and difficulties for all Schools of Medicine in this country, and, perhaps, especially in London, the past year has seen a considerable improvement in the financial position of the School, an improvement which has encouraged the Staff in the belief that they have been wise in undertaking new responsibilities and in incurring heavy expenditure in the determination that their School shall be worthy of its great past. In the large Provincial Cities in this country there are numerous well-equipped and admirably-conducted Medical Schools generously supported by the wealth of the town and encouraged by local patriotism. In the Colonies Over-seas young and active Universities have raised medical education to a high pitch of perfection. Yet, in spite of, and because of, the existence of these other Centres of learning, it is right that the Schools of the Capital should remain in the fore-front. From the Provinces and from Over-seas the stream must always set towards the Capital, and it is essential that as a School we should realise our responsibility and fit ourselves to meet it. The Staff is confident that the Fund inaugurated last year by the Treasurer for the Endowment of the School will continue to receive the recognition and support o those who understand the conditions under which Medical Education and Research are carried on in London.

Viscount Goschen, in calling upon Sir George Reid to present the prizes to the successful students, said that it was naturally a great pleasure to welcome the High Commissioner for Australia in their midst. The speaker looked upon Sir George Reid as an old friend of his. Their friendship had extended over a period of 22 years, from the time of their first meeting in Australia, when Sir George extended to him the great kindness which he always extended to Englishmen. At Guy's they were glad to have the Colonial atmosphere on their prize day, because it afforded them an opportunity of showing how warmly they welcomed there as students gentlemen coming from the Colonies. The residence of such students was an advantage both to Guy's and to themselves. It was an advantage to Guy's because it gave those connected with the institution an opportunity of broadening their outlook, kindling their imperial feelings, and making them acquainted with the views and opinions of the rising young men of the Britain beyond the seas. To the students themselves it was an advantage because it gave them the opportunity of acquiring their medical education in a hospital which kept abreast with modern thought and research. They were proud and glad to think that the traditions of Guy's Hospital were being so well maintained in the distant parts of the Empire, and that their own imperial policy and aspirations were an additional means of cementing the bonds which bound the Colonies to the mother-country.

Sir George Reid then distributed the following awards:—

LIST OF MEDALLISTS AND PRIZEMEN.

Open Scholarships in Arts.—Eric Roland Webb, Dean Close School, Cheltenham, £100. Gordon Frank Peters, Kent Coast College, Herne Bay, £50.

Open Scholarships in Science.—Eric Clark Hinde, Preliminary Science Class, Guy's Hospital, £120. Frederick Currer Miller, St. Paul's School, West Kensington, £60.

Scholarship for University Students.—Arthur Gerard East, B.A., St. John's College, Oxford, £50.

Open Scholarships in Dental Mechanics.—October, 1913, Hugh Muir Smith, £20. May, 1914, Richard John Gustavus Handel, £20.

SCHOLARSHIPS IN DENTAL MECHANICS FOR PUPILS OF GUY'S HOSPITAL.—October, 1913, George Dee, £20. May, 1914, Pierre Jean Hugo, £20.

JUNIOR PROFICIENCY PRIZES.—Leonard Snowden Debenham, £20. *Gordon Ernest Lovell Simons*, £15. Jack Joffé, £10.

THE BEANEY PRIZE FOR PATHOLOGY.—William Morris Lansdale, £34.

THE MICHAEL HARRIS PRIZE FOR ANATOMY.—Leonard Snowden Debenham.

THE WOOLDRIDGE MEMORIAL PRIZE FOR PHYSIOLOGY. Leonard Snowden Debenham.

THE HILTON PRIZE FOR DISSECTIONS (1913).—John Francis Carter-Braine, James Gaymer Jones, equal.

DENTAL PRIZES.—First Year's Prize in Dental Subjects, Geraint Arthur Pennant. Second Year's Prize in Dental Subjects, Donald Clewer, Maurice George Whitten, Certificate. Second Year's Prize in General Subjects, Maurice George Whitten, Frank Edward Welton, Certificate, Donald Clewer, Certificate. Prize for Operative Dental Surgery, Arthur Edmund Lowein, Wilfrid George Hollands, Certificate.

NEWLAND-PEDLEY GOLD MEDAL FOR PRACTICAL DENTISTRY.—Arthur Edmund Lowein, Reginald Joseph Ryland, Certificate.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY.—William Arthur Young, £20. William Edward Tanner, Proxime Accessit.

TREASURER'S GOLD MEDAL FOR CLINICAL MEDICINE.—Cassidy de Wet Gibb.

TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY.—Cedric Sydney Lane Roberts.

Sir GEORGE REID, after distributing the prizes and medals, said:—

Lord Goschen, Examiners, Professors, Doctors, Ladies and Gentlemen, and Medical Students:—I am delighted, as an Australian, to enjoy the conspicuous honour of distributing these prizes and medals. I do not know how it was that I got the honour, which I am sure I did not deserve, but, like most other men, I never allow that to stand in the way of taking it. I heartily reciprocate the kindly references which Lord Goschen made to me. Twenty-two years ago! Well, it would not have meant any great difference to me, but just think of the difference of twenty-two years in Lord Goschen! When he arrived in Sydney on the staff of Lord Jersey—that most distinguished man who has been a great friend to all the Dominions—I confess that, looking at him, I observed such a gaiety of spirit, such a venturesomeness of disposition, that I was not at all sure he would get out of Australia without getting into some serious trouble. He passed through that trying ordeal, however, enjoying an enormous amount of appreciation and intimacy, without, so far as I could see, a single rift in the lute.

Now, ladies and gentlemen, when I was looking at these young fellows who have succeeded, and whilst I offered them the most cordial congratulations, rather a sad recollection came over my mind which led me to think of the students in this great hospital who have not this time succeeded in winning prizes. I don't think so much of the successful men. They seem to be able to take care of themselves. But I do think very much of the unsuccessful students, and I hope that at the next time they will come forward, determined by superior industry, to take the places of my friends of this year.

Another reason why I sympathise with those who did not get prizes is that I never got a prize (laughter)—except once. Once in a cricket match—really I used to play cricket—when I was very young, I bowled out five of the boys of the rival school for about twenty runs. It was just before the time came for distributing the prizes. The teachers met together, so I heard afterwards, and said, "We must give that young Reid a prize for something or other, after winning that cricket match for us." They had an anxious consultation as to the particular subject on which they could venture to award me a prize without an undue strain upon the conscience. The consultation even became heated, and seemed to afford no prospect of possible settlement, until one of the intelligent teachers clinched the matter by saying, "Since we cannot agree on any particular subject, let us give him a prize for general proficiency." (Laughter.) And I see that some of the prizes awarded to-day are for proficiency! (Renewed laughter).

One of the things which I like particularly about this venerable foundation is the sign it gives me, that although we in the Dominions beyond the seas are accustomed to look upon the Mother Country as an old country, in many ways it is not old but young. I am delighted, now that I have come to reside here, with the number of proofs I get that although the *soil* of this country is old, the *soul* of this country is delightfully new, and delightfully vigorous, and delightfully promising. There is a new and broader England growing up every generation, and it is very necessary, because if we are to keep in the van of all the other nations, the children of England, and Scotland, and Ireland will have to be a long sight cleverer than their ancestors.

Now, looking over the statistics, I find that there has been an enormous development in the sphere, and scope, and usefulness of this great hospital, which is famous all the world over. During the last few years almost a dozen grand things have been done. Two things I wish to pick out as particularly agreeable to me. In the first place, the revenue of this great hospital has not declined. We were rather prepared, owing to a number of circumstances which I don't take a particular interest in—we were rather prepared to find that the support of such an institution as this would show signs of wavering and weakening. But, on the contrary, it has had a larger revenue than ever during the past year. That fact speaks well for England, and for London. In spite of its luxury, and the emphasis it places upon worldly success, one of the glorious things about this imperial city of London is the noble array of hospitals which the generosity of the people has maintained in order to come to the

assistance of those who are wounded and helpless in the battle of life.

The other thing which is particularly agreeable to me is the prominence which is given to experiment and research. If a student only learns that which is in the books, he does not know anything more than was known before he took to his books. It is the experiment and research of skilled men that will prove most important in the advancing volume of knowledge practically applied to the ills and dangers that flesh is heir to.

The doctors are often abused, but I had a life-long experience of them in Australia—you can see that—(laughter)—and I have always been on the most friendly terms with them, with the result that I cannot sufficiently admire their manner of dealing with their wealthy clients and with those who are not wealthy. The most practically charitable man on the face of the earth is the man who follows the medical profession. In all other occupations there is a strict line drawn between the department of the business making the wealth and the department of private charity bestowed by members of the firm. The doctor, however, is being charitable in the course of his business every hour and day of his life. (Applause.) I am beginning to preach now, so I will sit down.

Dr. HALE WHITE proposed a vote of thanks to Sir George Reid, than whom, he said, no man more representative of the Britain beyond the seas could have been found. It was Sir George Reid who had carried the Federal movement in Australia to a successful issue, and he had himself been Premier, and was now High Commissioner. It was appropriate for several reasons that they should have at that particular time a representative of the British Dominions to distribute the prizes. It was only during that week that the funeral of the greatest Colonial Secretary of modern times had taken place. Moreover, the previous week some hundreds of scientific people from this country had set sail for Australia to attend the meeting of the British Association, which illustrated very well how scientific bonds overstepped the seas and circled round the globe. Then, again, within the last few days, a statue of Captain Cook had been unveiled at the Admiralty Arch. Thus there were reasons of state, of science, and of history why that should be an appropriate occasion for Sir George Reid to be with them. According to geologists, ethnologists, and zoologists, Great Britain was quite modern when compared with Australia, which was already a continent with mountains and rivers, when what was now Great Britain was under the seas. Yet with all this antiquity, it was only 140 years since the first colonists arrived in Australia, so that in that Dominion they had solved the problem of combining the modern with the ancient. In Guy's Hospital, too, they had an instance of respectable antiquity, but old as it was, it was still quite modern, both in school and hospital. They knew that they were not quite perfect, the reason being that they wanted some more money. If any had money to give away—(Sir GEO. REID: No good with me!)—(laughter)—it could hardly be better expended. Within the last year they had had illustrations of how those who knew the school best were most willing to contribute. Dr. Hale White added that on the staff of the hospital they had gentlemen from the Colonies. Out of his last four house-physicians, three were from the Colonies, and better ones he would not wish to have. Many of their best students also came from the Colonies, and, taking them all round, there was no class of which they were more proud than those who came from the other side of the Equator.

Sir ALFRED FRIPP said that in the absence of his senior colleagues the honour had fallen upon him of seconding the vote of thanks. Dr. Hale White had said most of the things that he (the speaker) wanted to say, and, indeed, one could always trust the physicians to say everything necessary. He associated himself and all his surgical colleagues with the vote of thanks to Sir George Reid.

The vote of thanks having been accorded by acclamation,

Sir GEORGE REID said: So far as the gentlemen of this audience are concerned, I thank them, and there is an end of it. So far as the ladies are concerned, my profound regret is that I cannot thank each of them personally, individually, and exclusively. (Laughter).

The formal proceedings then concluded.

Pass List.

University of Durham.

FACULTY OF MEDICINE.

THIRD EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

The following candidates have satisfied the examiners:—

Materia Medica, Pharmacology and Pharmacy, Public Health, Medical Jurisprudence, Pathology, and Elementary Bacteriology: John F. Carter-Braine.

Pathology and Elementary Bacteriology: D. O. Richards.

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

Elementary Anatomy and Biology, Chemistry and Physics.—Pass List.—M. W. A. Sandoe.

University of Cambridge.

At the examination for medical and surgical degrees, held recently, the following were successful:—

Second Examination.

Part I. A. M. Ahmad, C. L. Odam.

Part II. G. L. Attwater, M. Chadwick, C. F. Pedley.

Third Examination.

Part II. P. R. Boswell, D. V. Pickering.

Clinical Demonstrations in Medical Cases by Dr. Lauriston Shaw.

THE following are notes of cases used by Dr. Shaw for clinical demonstrations during the recent course of Clinical Lectures :—

1. *Hypertrophied Lips.*—Clinical, Mr. Venables. A woman, æt. 26, was shown presenting the appearance observed in the reproduction of the photograph (Fig. 1). She was under treatment in Patience Ward, as a young girl, for (?) erysipelas. Ever since that time she has been subject to periodic swellings of different parts of her face, chiefly her lips, but also sometimes across her nose, or under her chin.

FIG. 1.

The acutely swollen parts, the patient says, smart, and are tender on pressure, but are slightly, if at all, discoloured. After each acute attack, the nose and chin return to their natural condition, but the lips have gradually become permanently enlarged, so as to produce a considerable deformity which makes the patient unwilling to go out of doors. The tissues are very indurated, and there is some slight ulceration of the mucous membrane at the junction of the lip with the gums. The patient presents no other signs of disease. This condition, which is comparatively rare, is said to be usually a sequela of syphilis, but there are no indications of other syphilitic lesions, and no suggestive history in this woman. Wassermann's reaction is indefinite. The hypertrophy is probably due to general lymphangiectasis of the lips, resulting from lymphatic obstruction, and may be regarded as analagous to elephantiasis. A plastic operation with removal of the redundant tissue has been suggested to the patient at another hospital, but was declined. Mr. Hughes has seen the patient, but is averse to any operative interference until the septic condition of her mouth and gums is removed. It is suggested that some form of lymphangioplasty might possibly be of advantage. Meanwhile there is a proposal to try the effect of salvarsan.

2. *Aphasia and partial hemiplegia in a young woman.*—Clinical, Mr. Tanner. A girl, æt. 22, was admitted for a sudden attack of aphasia accompanied by transient partial hemiplegia. The girl was said by her friends to have been "not quite normal" all her life. She had never done a good week's work, though she had been a factory hand for many years. The patient went to bed well one night and when she woke in the early morning she found she could not speak properly and had some unusual sensations, or weakness, it is not clear which, in her right hand and right leg.

When first seen a day or two later she had still well-marked trouble in her speech and some inability to use her right hand for delicate operations but no marked loss of power in gripping. The leg seemed perfectly restored.

Defining aphasia as a defect in the mental processes of speech which interferes with a patient's use of language, it was necessary to discover whether the impairment in this case was in understanding others or in expressing herself. As far as spoken language was concerned, the patient had no difficulty in understanding anything. She instantly obeyed commands and clearly understood all that was said to her. The form of sensory aphasia called *word deafness* was, therefore, entirely absent. Her obvious difficulty took the form of motor aphasia, sometimes called *aphemia*. She could not express herself in spoken language. This was easily demonstrated, for she was a very talkative young person, and was both

annoyed and amused at her failures to get hold of the right word. This difficulty was also clearly shown when different objects were given to her, and she was asked to name them and to state their substance and their use. As regards written language it was less easy to demonstrate the existence or nature of her defect. *Word blindness* was absent. She obeyed commands written down and shown to her, and appeared to understand what she read aloud correctly. Her power of writing was strictly limited, but it was difficult to decide how far this was due to the defect in the mental process of speech called *agraphia* and how far to the mere impairment of muscular movement and co-ordination. The association of aphasia and partial hemiplegia always justifies the diagnosis of an organic cerebral lesion. Dr. Shaw said he had once seen such a combination cleverly acted by a nurse who had become neurotic from overstrain in constant charge of a patient dying slowly from a hæmorrhage into the left internal capsule. With regard to the exact diagnosis of the nature of the pathological lesion, the sudden onset, and the complete absence of signs of chronic intracranial pressure, *headache, vomiting, vertigo, optic neuritis* and *fits* made a neoplastic lesion unlikely and a vascular lesion probable; and of the three vascular lesions the sudden onset made thrombosis unlikely, and left the diagnosis resting between hæmorrhage and embolism. There was no cardiac lesion to make embolism probable, and no renal disease or high arterial tension to explain a hæmorrhage. The proneness of the blood of young women to undergo spontaneous thrombosis justified a guess that some intracardiac clotting had been followed by the displacement of an embolus which had become lodged in a small branch of a cerebral artery. Dr. Shaw partly attributed the rapid improvement in the patient's power of speech and in the use of her right hand for delicate manipulations to the interest taken by her clinical assistant in the process of re-education of the lost faculties.

3. *Single Abscess of the Liver.*—Clinical, Mr. Blake. A native of West Africa, aged 43, who had resided in England continuously for the last 19 years, was admitted for a painful lump in his right hypochondrium. The pain had been gradually developing during some months, and a lump had only been noticed quite recently. There was no history of any previous illness which seemed to have any bearing on the case. Particularly was it noticed that at no time either whilst in the tropics, nor since he had left them, had he suffered from dysentery, nor had he ever been troubled by pain in the appendix region.

Physical examination made it quite clear that the patient was suffering from an unequal enlargement of the liver. A tumour, as large as a cricket-ball, protruded from the anterior surface of the liver below the right costal margin. The tumour was rounded, smooth and elastic. It did not give a distinct sense of fluctuation, and was tender on palpation. The mass moved with the liver on respiration, but the mobility was restricted, suggesting that there were adhesions between the tumour and the anterior abdominal wall. Such a mass it was thought must necessarily be either an *abscess*, a *gumma*, a *new growth*, or an *hydated cyst*. It was decided to investigate the number of white blood corpuscles in the blood, and to discover whether either the Wassermann test, or the hydatid complement-fixation test was positive. A high leucocyte count was reported, and the Wassermann test was negative. On this it was arranged, without waiting for the hydatid test about which some difficulties were encountered, to ask a surgeon to operate, in the expectation of discovering an hepatic abscess. A single abscess, containing some ounces of thick pus, was opened, and the patient made an uninterrupted recovery. Nothing further was discovered to throw light on the origin of the abscess. The gross features of the lesion were those of the condition which used to be called tropical, or single, abscess and is now generally termed amœbic abscess. Although the patient was a native of the tropics, he had not resided there for 19 years, and had never suffered from any form of diarrhœa.

4. *Muscular Pseudo-hypertrophy.*—Clinical, Mr. Venables. A boy, æt. 13, came to the hospital because of the swelling of his muscles and of an occasional difficulty in walking in which his legs became stiff and unmanageable for a few minutes at a time. His appearance was very striking: nearly every one of the muscles of the trunk, neck, and both limbs showed some enlargement, the boy's figure resembling that of a "strong man." His power did not correspond to the promise of his muscular development and so seemed to justify the title "pseudo"-hypertrophy. On the other hand, none of his muscles demonstrated the striking weakness which is a common feature in cases of pseudo-hypertrophic paralysis. The patient was well able to rise from a low seat with his hands above his head, and in rising from the recumbent posture on the floor did not demonstrate the characteristic

"climbing up himself" method. The reflexes and knee-jerks were all normal and no sensory phenomena were made out. The case seemed to belong to the group of myopathies but presented much more hypertrophy and less weakness than was usual in cases of pseudo-hypertrophic muscular paralysis. There was a history of somewhat similar trouble in an elder brother and a sister of the patient. The patient was transferred from Clinical to Addison ward, and is now said to be regarded as a case of myotonia pseudo-hypertrophica, a form of Thomsen's disease.

FIG. 2.

5. *Acute Grave's disease.* — Clinical, Mr. Bevan-Brown. A young man, aged about 24, was admitted with a provisional diagnosis of acute thyroiditis. He was employed in a healthy occupation which he enjoyed, and the duties of which he was able to accomplish without any stress or discomfort. He described himself as being, until 14 days ago, absolutely healthy, and without the least care, anxiety, or cause for unhappiness. A fortnight before admission he noticed the circumference of his neck to be rapidly increasing without any pain. Within a week its measurement was said to have enlarged by inches. At the end of the first week there was some discomfort of a "choking" character, which seemed to include some trouble, both in swallowing and in breathing, but this rapidly passed off and was quite imperceptible when the patient was admitted.

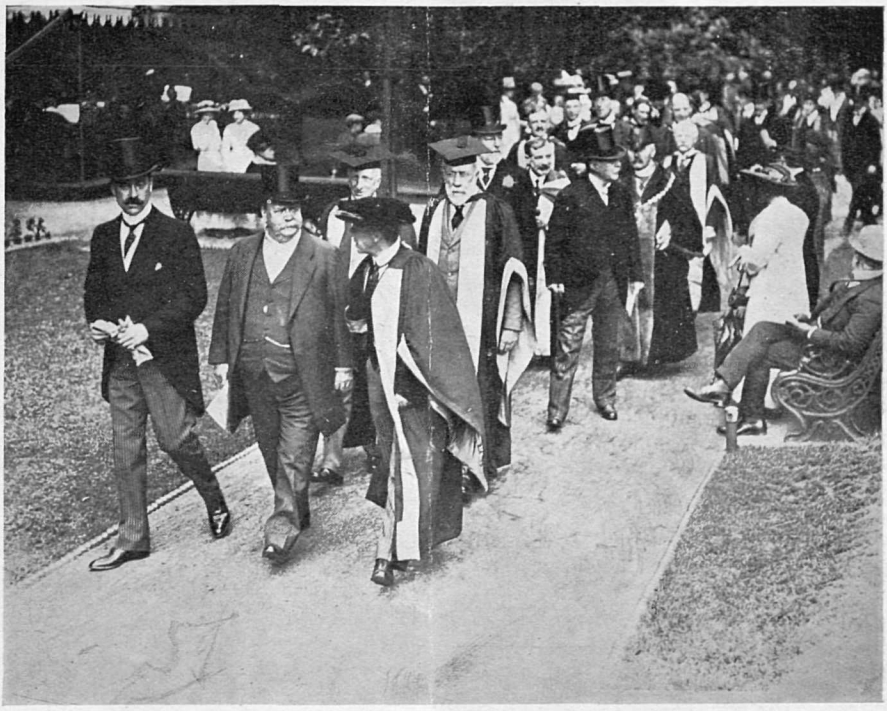
The patient's neck when examined on admission, and as seen at the demonstration, presented the characteristic appearance of a perfectly uniform enlargement of the thyroid gland. In considering the validity of the provisional diagnosis, it was pointed out that although of the classical signs of inflammation, *tumor* was present in marked degree, *calor*, *rubor*, and *dolor* were all distinctly absent.

At the moment of admission it was thought that no other physical signs of any sort could be detected, and particularly was it agreed by all that no prominence of eyeballs could be detected. Certainly the pulse was not accelerated, and there was no tremor nor any sign whatever of a neurotic temperament.

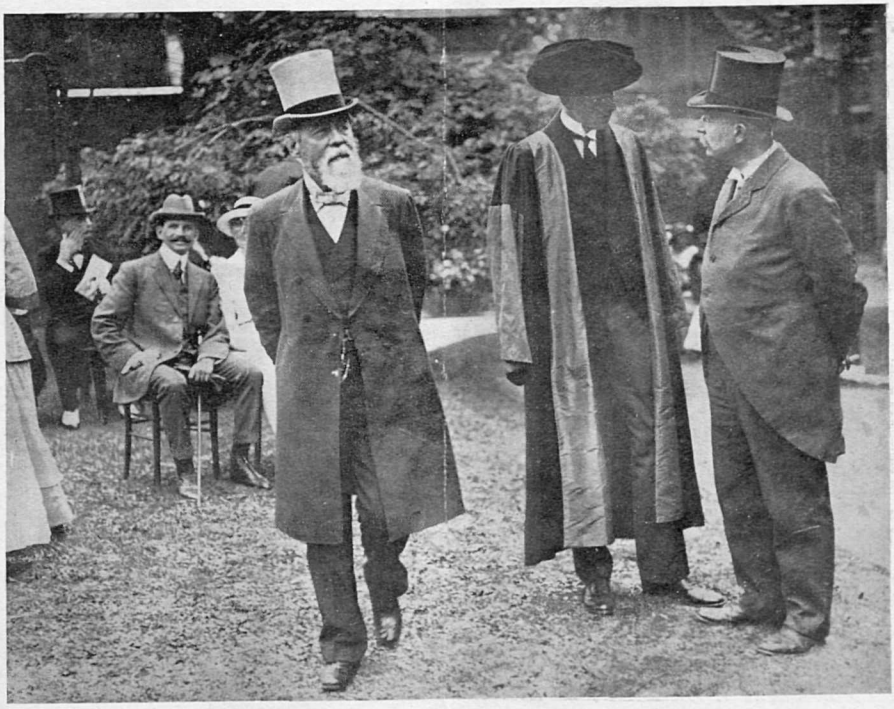
Nevertheless, it was thought most likely that the case must be one of Grave's disease of acute onset, it being remembered that any one of the classical signs may, at least in more gradually oncoming cases, be the only indication of the condition for very considerable lengths of time. Although in a good many cases some mental stress was recognized as a contributory factor in causation of the disease, its complete absence in this case could not be regarded as a valid point against the diagnosis. The absence of any real knowledge as to its nature and cause is still a prominent feature of this disease. After a few days it began to be recognized that there was a slight suspicion of a "staring" appearance in the eyes. Some observers thought they could demonstrate the want of co-ordination of movement between upper eyelid and eyeball when the patient looked towards his feet, which is called von Grœfe's lid sign. The appearance of the patient at the time of the demonstration is shown in the accompanying portrait (Fig. 2).

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

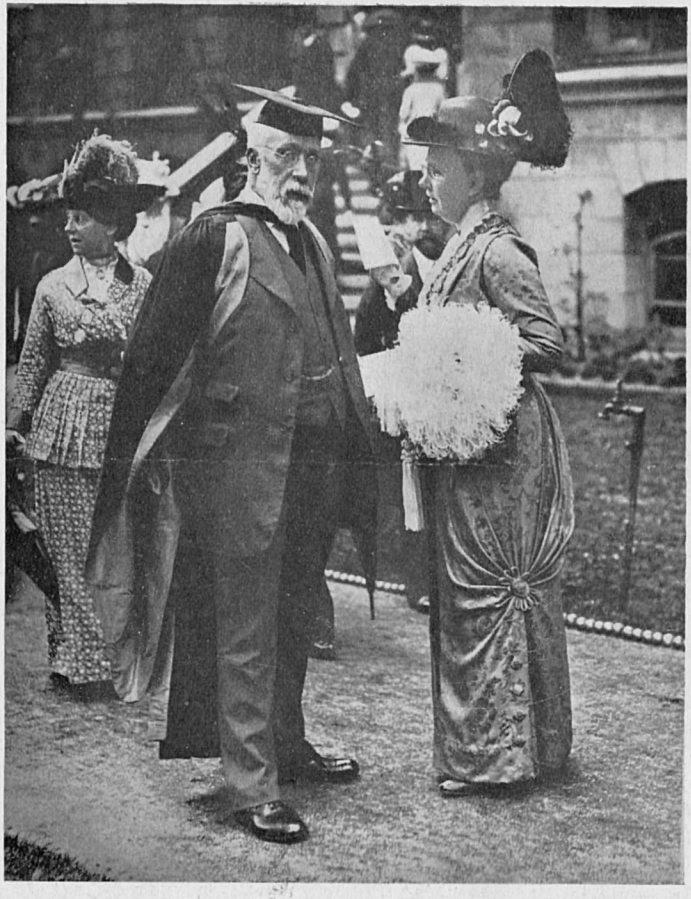
Distribution of Prizes, July 9th, 1914.



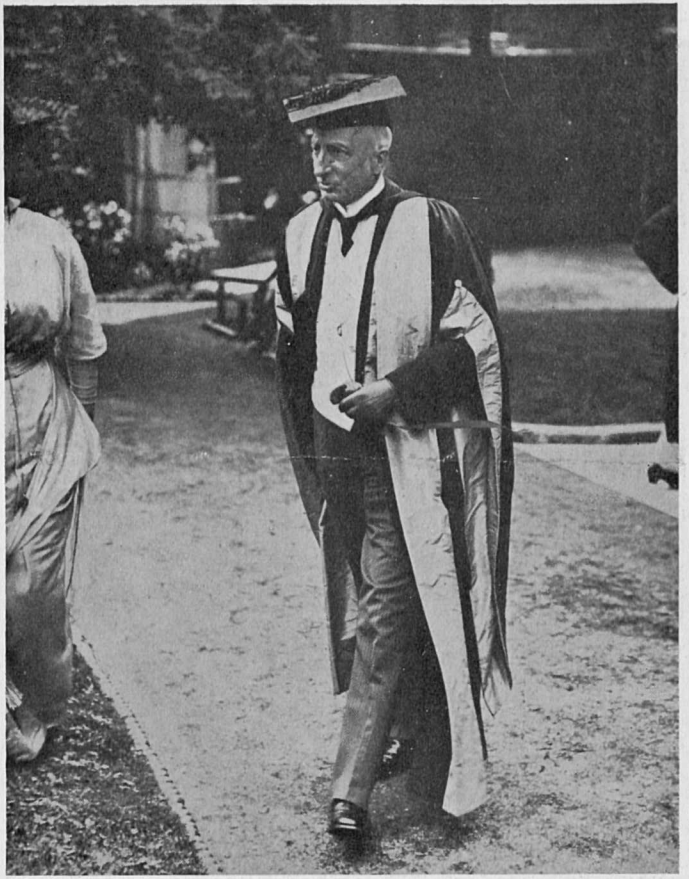
SIR GEORGE REID with LORD GOSCHEN and Dr. CAMERON.



SIR JAMES GOODHART and Dr. PITT.

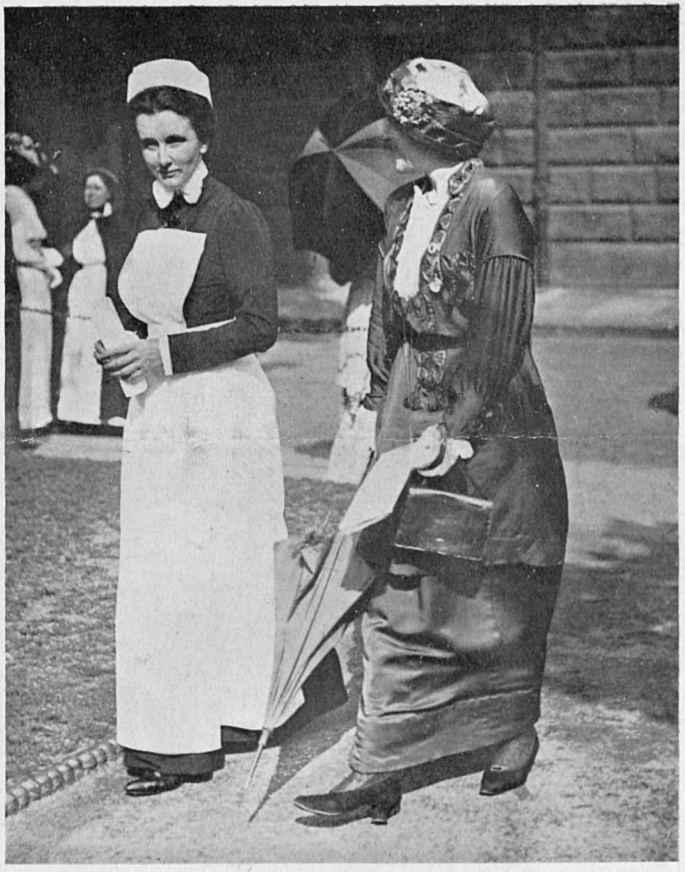


SIR GEORGE SAVAGE.

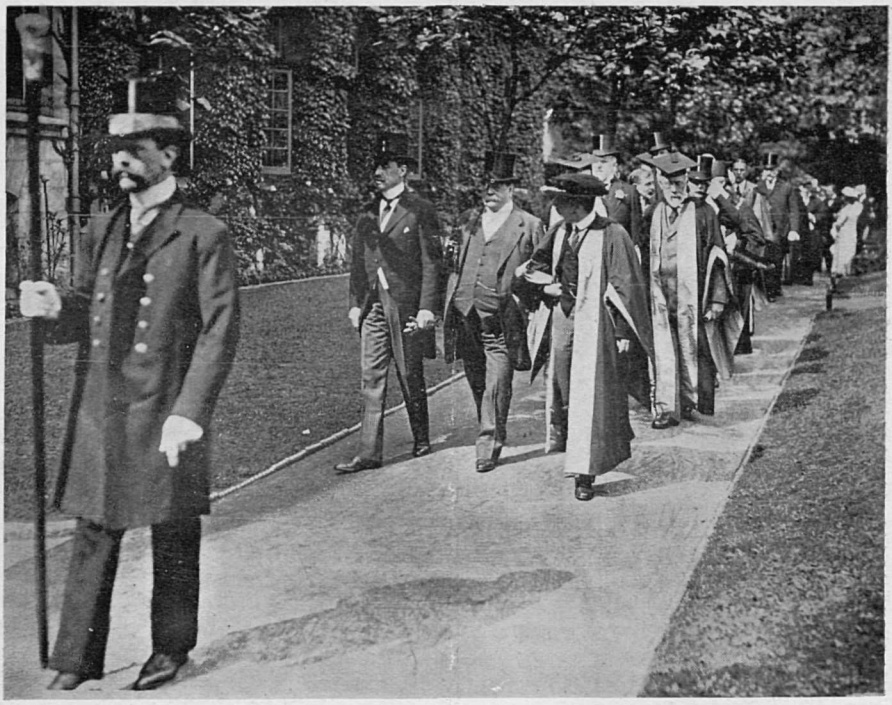


Dr. FREDERICK TAYLOR.

THE DEAN.



THE MATRON.



The Procession on its way to the Theatre.

IN THE PARK.

The Abderhalden Reaction.

THE principle of the Abderhalden reaction, in so far as it is applied as a clinical test for the diagnosis of pregnancy, is briefly as follows:—The normal placenta consists of an arborisation of chorionic villi floating freely in a bath of maternal blood. It constantly happens that fragments of the syncytium which clothes these villi become detached and enter the maternal blood-stream. The maternal blood reacts to these substances, as to any other foreign matter which may be introduced into it, such as bacteria, by forming antibodies. In the case of pregnancy these antibodies take the form of ferments, whose function it is to split up the syncytial fragments into the amino-acids of which they, like all protein substances, are constituted. The presence of such a ferment in the blood is, therefore, taken as an indication that the patient in whom it occurs is pregnant. The Abderhalden test is a test for this ferment. A preparation is made of human placenta tissue; this is placed in a dialysing tube, and serum from the patient is added to it. If the patient is pregnant the ferment which her serum will contain will act on this placenta tissue and liberate amino-acids from it; these will pass through the walls of the dialyser-tube and may be recognized by means of a special reagent, called ninhydrin, in the water outside. If the patient be not pregnant no such action will occur. A positive reaction indicates that the woman is pregnant, a negative, that she is not pregnant. The test is given so soon as the trophoblast is formed, *i.e.*, in the first two or three weeks after conception.

Such is the principle of the Abderhalden reaction: a large number of people discredit it altogether, both on theoretical and on experimental grounds, for many who have tried it have failed to obtain trustworthy results. Those who do claim to use the method successfully do not, as a rule, pretend to obtain a higher percentage of correct results than 75, owing to the difficulties of the technique which admits of many sources of error.

The principle has been extended to form a clinical test for the diagnosis of malignant disease, and of various other conditions, such as cerebral abscess, tumours of the liver, and, in fact, any localized lesion involving tissue destruction; also, of infectious disease, such as tuberculosis. In each case it is supposed that a ferment is elaborated, whose function it is to split up the particular abnormal protein which has been discharged into the circulation. The serum is, therefore, allowed to act, not on placenta-tissue, but upon tissue preparations of carcinoma, brain, liver, tubercle bacilli, or whatever protein substance is supposed to be undergoing destruction. The ferment formed in each case, according to the theory, is specific in its action for the particular kind of protein which has evoked it, and to be inactive towards protein from other sources. T. B. H.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

A Grumble from Egypt.

DEAR MR. EDITOR,—I crave indulgence to encroach upon your valuable space, and air a small grievance.

What has happened to the Secretaries of the Cricket and Swimming Clubs? I have not been able to find any account in the GAZETTE this summer of the doings of these Clubs. As each GAZETTE arrives, one at once peruses your scholarly "Passim," and then turns to the end in order to see the latest scores, but is met with obituary notices, and, perhaps, a case of an "unusual blood count in typhoid fever." Both are excellent in their way, but unsatisfying to one living in a land where typhoid fever, "battle, murder, and sudden death" are common occurrences.

In your desire apparently to ignore all sporting news you even go so far as to omit "Nursing News," that one small column of Romance beloved by susceptible dressers and ward clerks.

You will reply (don't dismiss me with silent scorn), that it is not your business to go round collecting results from slack secretaries—not—likely—as our friend G.B.S. has it. Still, "thanking you in anticipation."

Cairo, I am, yours, etc.,
1st July, 1914. J. T. TABASCO.

[We sympathise with our correspondent, cheerful in spite of his grumblings, and acknowledge freely that he has ground for complaint. He was, however, just a little impatient. His letter crossed the last GAZETTE on its way to Egypt, and no doubt by now he is happy in seeing how well the Cricket Team have done in their matches to date. The "Nursing News" in that number is probably not what he was interested in, but we can tell him in advance that all his old friends have left by now. However, we will do our best to provide him with an account of the recent changes in the near future.

We do not wish to shelter ourselves behind the defence he so obliging provides for us. Knowing the genus secretary as we do, we realize that it is undoubtedly our duty to worry them if our readers are to have reports of the activities of the various clubs. Ed. *G.H.G.*]

A Substitute for a Spirit Lamp.

DEAR SIR,—May I draw attention to a little-known use to which a tablet of Hexamethlenetetramine can be put—namely, as a substitute for a spirit lamp. Apply a match and it will burn slowly without smoke or smell, and with a hot flame.—Yours faithfully,

C. W. HOGARTH.

Some Remarks on the Extraction of Teeth.

DENTAL CLINICAL LECTURE BY
MR. J. B. PARFITT.

GENTLEMEN,—The wholesale extraction of teeth is, we are glad to feel, getting less necessary as knowledge advances; nevertheless, the operation is still a most important part of the work of a dental surgeon. Many people may think that taking a tooth out is as simple a thing as getting a nail out of a board; there may be, for all I know, right and wrong ways of getting nails out, there are certainly more easy and less easy ways of extracting teeth, and success in extraction will, in general, depend more on a correct understanding of the mechanical principles involved than on great strength or zeal.

My excuse for choosing such an elementary subject is that I think these mechanical principles are not sufficiently understood, or if they are understood they are not always acted upon. The hard and unyielding nature of the teeth and their sharp demarcation from the surrounding tissues renders the mechanical discussion of the problems connected with them an easy matter.

It is well to consider the actual problem of extraction and the mechanical principles of the instruments separately, and I will take the instruments first. Of the various kinds of elevators there are two in common use, generally called "straight" and "curved." The straight elevator is simply a narrow steel wedge set in a convenient handle. In the commonest form one side of the wedge is quite flat, the other, and opposite one, being rounded to such an extent that it meets the flat one in an edge all the way round; the distal end is not square like a chisel, but has its two angles rounded off so that the flat side ends in a fairly elongated oval, the margin of which is kept quite sharp.

This instrument can be used in several different ways :—

(1) As a wedge. If it is pushed between two teeth or roots, or, of course, between any two objects whatsoever, it will tend to drive them apart. The flat side would, as a rule, be turned towards the tooth to be extracted, and as the wedge is a thin one its mechanical advantage would be great and it would exercise a correspondingly great force on the root, and in a direction normal to the flat face of the elevator. The direction in which the force is exercised will, in most cases, prevent its being usefully employed in this particular manner; moreover, its great power makes it quite possible to do serious mischief with it, especially if it is allowed to slip and make a deep wound in the soft tissues. Perhaps one of the most useful cases for the employment of the "wedge" action of the straight elevator is in the extraction of a tooth or root which is entirely crowded out of the arch. The bone over such a tooth is usually quite thin, so that its extraction is, as a rule, an easy matter.

(2) The straight elevator may be used as a lever of the first order. This "crowbar" action is, like the last, a very powerful one exercised in a direction normal to the flat face of the instrument, and for the same reason will have but a limited use. It would come into operation chiefly in the turning out of a root already loosened by some other means. A method of extracting roots by a sort of "crowbar" action from below has been described. A straight elevator is made to cut its way through the side of the alveolar process until it gets under the apex of the root, which can then be levered towards the mouth of the socket.

(3) The most useful action of the straight elevator is a rotation about its long axis, the motion being the same as that of a screw driver. By this method of extraction the root is really "elevated." The instrument, which should be a narrow one, is pushed between the necks of the two adjacent teeth, the flat side being towards the one to be taken out. It is then rotated about its long axis so that the sharp edge of the side of the elevator, near the point, is made first to cut into the neck of the tooth, then by a continuation of the same rotation it lifts the tooth bodily in its socket, and once loosened, the rest of the extraction is an easy matter. A mechanical analogy to an elevator used in this fashion is a cam on a rotating shaft.

Here, again, the mechanical advantage, and consequently the power, is great, the actual range of action being accordingly small; the effective resistance or bearing is afforded by the column of bone between the two teeth.

There are many kinds of elevators curved in various ways, but the form generally spoken of as "the curved elevator" may be thought of as being derived from the straight one by bending the last half inch of the blade through something less than a right angle in a plane

parallel to that of the flat face. The analogy to a cam on a shaft becomes still more obvious; the cam, however, is in this case much longer than it is in the straight elevator, consequently its power is less and its range of movement greater, and its use is limited to those places where there is plenty of room for its action.

The "cam and shaft" action of the curved elevator is very useful in the removal of one root of a lower molar when there is an empty socket adjoining it. The blade of the elevator is passed to the bottom of the empty socket, the handle is then turned so that the blade cuts through the intervening septum and then forces the root up from below. The motion which must be given to the handle in order to effect this manœuvre is mostly a rotation about its long axis, as in the straight elevator, but as the bent part of the blade is not at right angles to the straight part, the handle will, in addition, move round part of the surface of a cone whose apex lies at the junction of the straight and curved parts of the blade.

The curved elevator can also be used as a wedge; if, in a similar case to the one just described, the blade be forced down between the root and the standing tooth adjoining it, the root will easily be turned into the empty socket. An isolated lower wisdom tooth, especially if it is tipped forwards, can often be extracted by working the curved elevator "wedge" fashion down into its socket along the front of its anterior root.

I will now pass on to the consideration of the forceps. A pair of tooth extracting forceps is nothing but a temporary handle to the root, just as a spanner is only a temporary handle to a nut. This analogy is no mere fancy, as some of the principles of the forceps can be most easily illustrated by reference to the action of a spanner. As with a spanner it is very necessary that both handle and jaws be made strong enough to stand any force likely to be used upon them without bending either temporarily or permanently, beginners sometimes make the mistake of using light root forceps for solid and firmly implanted molars. Firmness of grip of blades on the root is naturally a matter of the first importance. Apart from accuracy of fit of blades to root, this will depend chiefly on the power exercised by the flexor muscles of the fingers in keeping the handles approximated, and on the mechanical advantage at which that power works. Various types of forceps may differ as much as a hundred per cent. in mechanical advantage of grip. Mechanical advantage is often sacrificed to some extent for convenience of shape and length of reach, the disadvantage of this being that if a tooth is very firmly implanted so much power is required for merely keeping a grip on the tooth that the proper movements of extraction are seriously interfered with.

Even with a fairly good grip there may be a tendency for the forceps to slip off when any attempt is made to *pull* the root out. This can be counteracted by exercising strong pressure *towards the apex of the root* during the whole of the rotation or other movement whereby the attachment of the root is loosened. When loose, but not before, the root can be readily lifted out of its socket by substituting a pulling movement for the pushing one.

The next thing for consideration is the angle the axis of the handles makes with that of the blades. This has no influence on the grip, but a great deal on the movements of extraction themselves. These are two: a rotation of the root round its long axis, and a lateral dislocation almost always in the plane passing through the two blades. These are the movements which must be given to the *blades* of the forceps.

The movements that must be given to the handles need not be similar to those executed by the blades; in fact, they will only be so when the axes of the handles and blades are in the same straight line. This is the case in the common upper straight forceps; in these a simple rotation of the handles or a simple movement of them inwards or outwards will produce an exactly similar motion of the blades. In consequence of this fact upper straight forceps are the simplest of all in action, and while they may not actually give more power, they certainly give more facility and control over the movements of the root than do more complicated shapes. In certain of the bayonet shapes the axis of the blades is not in the same straight line as that of the handles, but in a line parallel to it. The purpose of this arrangement is to give backward reach, but (unless the two axes are inclined to one another) the amount of extra reach is trifling, being in fact equal to the perpendicular distance between the axes. The action of this form of bayonet forceps is a simple one, rotation of the blades being produced by taking the handles round the circumference of a cylinder, and inwards or outwards movement of the blades in any plane by a similar movement of the handles in a parallel one.

In all other cases except these two the axis of the handles meets that of the blades in an angle. The amount of bending of the handles away from the line of the blades may be a right angle or less, very rarely more, and the direction of bending may be in the plane passing through the two blades or in a plane at right angles to it. There is, of course, no reason why the bending should not be in some other plane, and such instruments are made, but apparently they are not much used.

Of the forceps with handles and blades in the same plane, the commonest type is that of the well-known "lower hawk's bills" with the two axes at right angles to one another. The movements of this instrument are very simple: rotation of the blades is effected by sweeping the handles round in a circle the plane of which is at right angles to the long axis of the root to be extracted, and an outwards (or inwards) dislocation of the root is brought about by lowering (or raising) of the extremities of the handles. Instruments of this type with the blades set at some other angle than a right angle are less commonly used, and will, therefore, not be further mentioned.

I will now pass on to the forceps with handles bent in a plane at right angles to that of the blades. Those whose handles are bent half a right angle or less away from the axis of the blades include the ordinary upper molar and root forceps, those bent from half a right angle to a right angle, the so-called lower straight forceps. If the angle is a full right angle the action of the instrument is as simple as that of the lower hawk's bills, rotation of the root being brought about by sweeping the handles round in a horizontal circle and dislocation outwards or inwards by a rotation of the handles about their long axis.

If the inclination of the two axes to one another is less than a right angle, the action is less simple. Rotation of a root is effected by sweeping the handles round the surface of a cone whose apex is at the junction of handles and blades. Simple lateral dislocation of a root is brought about partly by a movement of the handles sideways in their own plane, similar to the movement of upper straight forceps under similar circumstances and partly by a rotation of the handles about their long axis, the rotation being more pronounced the greater the angle between the handles and blades.

The details of extraction depend on the characters of the tooth to be taken out, but there are one or two simple principles which apply more or less to all extractions. The teeth are not wedged tightly in their sockets; in fact, they often fall out of their sockets in a dried skull; they are, as it were, slung in their places by the fibres of the alveolodental membrane, and when these fibres are burst, either by rotation of the root or elevation in its socket or by lateral dislocation, the tooth is found to be quite loose and hardly requires any "pulling" at all.

Another point which may be mentioned is that the facility with which an extraction may be performed depends to a very considerable degree on the difference in hardness between the tooth and the tissues in which it is embedded, and anything which helps to accentuate this difference helps to make the extraction an easier matter. For instance, the alveolar process, although, as a rule, much more easily broken than a tooth root, requires a certain, though small, time in which to yield, and the sudden application of a great force, even in the proper direction, may cause the tooth to break. This is because the rapidly increasing force, instead of expending itself on the actually more yielding socket, causes the strain in the root to increase to the breaking point. Again, sharpness of instruments, whether forceps or elevators, enables them to cut through gum and bone without making any impression on the tooth with any force likely to be employed. This is of the greatest assistance in feeling for and getting a firm grip on the root; in fact, extracting a buried root with blunt instruments is as awkward a matter as picking up pins with gloves on.

The main rules for the extraction of individual teeth are so well known that I will only make a short reference to that part of the subject.

The ten upper anterior teeth are, as a rule, easily extracted by rotation or outward dislocation according to the shape of their roots. Wherever straight forceps can be used at all they will generally be better than any other kind. It must not be forgotten that the first upper premolar often, and the second sometimes, has two roots.

Upper molars are strong teeth firmly implanted, consequently it is a mistake to use weak and long-bladed forceps or firmness of grip will be sacrificed; moreover, when broken down they give poor holdfast, and so a strong pressure *upwards* must be maintained until the outward dislocation is accomplished. Another point worth noticing is that owing partly to the bending of the handles of the forceps, already referred to, but also partly due to a slight spiral arrangement of the roots themselves, an upper

molar requires a certain amount of rotation in bringing it out of its socket—a right-handed rotation for a right-side tooth and a left for a left. This is often especially noticeable in the third molar.

The lower six front teeth are most easily removed by outward dislocation with the hawk's bill root forceps, and the four lower bicuspids in the same fashion or by rotation, their roots being sometimes almost circular in cross section. Frequently these roots are thin, or crooked, or both, and, therefore, liable to fracture. When the apex of a lower bicuspid is left behind it is sometimes necessary to pass the forceps down outside the alveolar process and grip bone and root together, but this is always to be avoided, if possible, because of the nasty wound it makes.

The first and second lower molars are by most operators extracted with hawk's bill forceps, although others prefer the so-called "straights," and there is no doubt that this instrument requires less room for its manipulation than the other.

It is a good thing to make a practice of removing the lower wisdom tooth with the straight elevator by the third mode of action I have described and compared to that of a cam and shaft. The backward curve of the roots of this tooth and the density of the bone surrounding it render direct elevation in its socket a peculiarly suitable movement for its extraction. The practice of reserving the elevator for cases where other means have failed is a bad one; it both predisposes to failure, in consequence of the use of a less mechanically sound method, and makes the operator less familiar with the more sound one just when he wants it most. Other uses of elevators in extracting lower teeth I have already referred to.

Nursing News.

"Nursing Times" Lawn Tennis Challenge Cup.

The Guy's representatives are still continuing their triumphant career in this competition, and have now reached the Final. Their opponents will be the winners to the match between North Western Hospital and St. George's Hospital. In the third round Guy's beat Shorditch Infirmary.

Nurses Ryan and Rowan won ... 6–1, 6–0, 6–2
Nurses Hayne & Williams won ... 6–0, 6–1

In the Semi-final they beat St. Mary's, Carshalton.

Nurses Ryan and Rowan won ... 6–2, 6–1, 6–3
Nurses Hayne and Browning won 6–2, 6–2

Fighting a Delusion.

(*Continued from page 246.*)

V.

The doctor had dropped into three or four cottages and was paying his last visit for the afternoon.

"Yes, the little chap will get all right, never fear," he was saying to an anxious-looking woman who followed him down the neatly kept path. He broke off the conversation abruptly as he looked round and could see nothing of Geoffrey Marsh whom he had left waiting for him outside. For one moment he stood puzzled, looking up and down the lane, feebly lit by two lamps at either end.

"What's he up to now?" he asked himself. Then he muttered, "Gad, he may commit suicide as an imperative duty!" Suddenly an idea struck him, and with rapid steps he took a short cut through some fields to the outskirts of the town, and passing through some narrow streets he quickly arrived at the churchyard. A few paces ahead of him, in the shadow of the church, he saw the now familiar figure of Geoffrey Marsh standing beside a grave. With bent head and rounded shoulders he stood immovable like a statue gazing apparently at some object. The doctor cautiously approached and stood beside him. Marsh did not seem to hear the footsteps as the other man crossed the gravel path. He appeared hypnotized. As the doctor followed his intent gaze he saw something glittering in the long grass above the mound. He bent down and saw a piece of a broken mirror. He kicked it aside quickly, and at the same moment grasped his patient by the arm. The sudden action seemed to wake him from a dream. Before he could say anything the doctor spoke—

"Come away, man, come home. Come with me.' Then without another word he led him unresisting back to the house.

Like a cat watching a mouse so the doctor watched Geoffrey Marsh. He had sworn to himself to save him. He had stepped in between the man and impending death. He was fighting his delusion. He meant to conquer. He meant to give this man back to life—sane. Let us watch further the fight.

A couple of hours had to be got through before dinner at half-past seven. These were filled by the doctor with another demonstration of "Life." As his patient sat moodily in the dining-room in an armchair before the fire Norcross once more stirred up the household with the sound of his presence. He bustled about the place singing snatches of music-hall doggerel, dodged in and out of the room for imaginary things on tables and in cupboards, pulled the blinds up and pulled the blinds down, poked the fire and rattled the fireirons. He worked himself up into a fictitious state of high spirits to impress upon this unhappy man,

crouching silently in the armchair, that he, at all events, found life worth living, and at that hour of the day was verily bubbling over with it. Might not some reflex action be stirred up within those tired brain cells, he thought, as he continued to bustle around?

Dinner was at length announced by a solo on the gong played with unusual vigour. Throughout the meal the doctor's patient sat moody and silent, refusing to touch any food in spite of the doctor's entreaty. He brushed aside decisively offers of wine; and every now and again he glanced nervously at the clock and started as it struck the quarters. The doctor watched him furtively and respected his wish for silence.

At last dinner was over. It was a ghastly meal, indeed, for both doctor and patient. Presently the former got up from the table and, standing with his back to the fireplace, started talking.

"Seen the papers to-day? Riots in Paris. Fall of the French Ministry. They'll be making things hum over there. Only once saw a real riot. Trafalgar Square—military called out—most stimulating—thoroughly enjoyed myself, perched up against the railings by Union Club in Cockspur Street, where I had placed myself so as to ensure a way of escape."

"A way of escape?" echoed Marsh, dreamily, catching the last words. "*There is no way of escape.*"

The doctor quickly changed his tone. "Rot, man, you are not going on that tack any more. Men like you have their work to do. Men like you are wanted. You're out of sorts at present, but with a little rest and possibly change of air later on you'll feel as fit as a fiddle."

Marsh shook his head feebly and looked more wearily at the doctor.

"Mr. Marsh, you must go to bed."

"Why?"

"Because you are tired."

"You know I have only a few hours to live."

"Nonsense. You are going to be a sensible fellow."

"I am going out to the grave," he answered in a dreamy way, waving his hand towards the window.

"Bosh, man; buck up. You have life before you. *Life*, I tell you —"

Marsh got up from his chair and was moving towards the door when the doctor sprang forward and caught his arm.

"My good friend, sit down," he said, kindly but firmly. "If you won't go to bed, let us have a pipe together."

"I am going out," was the reply.

They stood looking at one another for some seconds without speaking. The weak man twitching nervously about the mouth in the effort of resistance. Then the strong man spoke.

"I am going to give you something that will do you good."

"Not you. No more drugs for me."

"Well," answered the doctor, as though making a concession. "Just a prick of a needle." As he spoke he produced a small silver case from his hip pocket, opened it and withdrew a tiny syringe.

The clock struck the half hour, and Marsh started as he heard it. It was in vain that the doctor urged his patient to consent to have a hypodermic injection. After some argument the doctor suddenly changed his attitude.

"Well, look here, shall I come with you?"

"Yes, if you like," he answered slowly.

"Well, let me put on my boots. Wait here for me."

Norcross left the room, and as he did so Geoffrey Marsh walked up and down, nervously biting his nails. From time to time he glanced at the clock, which seemed to have a peculiar fascination for him. The hour of nine was striking in deep solemn tones, a melancholy echo to the unhappy man's thoughts. Scarcely had the sound of the last stroke passed away when the door opened quietly and the doctor entered the room. In one hand he held a black bag, and behind him appeared the broad prosaic figure of the groom. The latter stood at the door and kept his eyes on the doctor, who placed the bag on the table and proceeded to remove its contents. And Geoffrey Marsh watched, too, his nervous fingers twitching the while, for he seemed to see some hostile intent in the doctor's proceedings. Out of the bag Norcross took a bottle, and as he placed it on the table Marsh read the printed label on the side.

"Chloroform," he said. Then in louder tones, with a note of fear in them, "What are you going to do with chloroform?"

The doctor picked up the bottle in one hand, and with the other grasped a gauze mask that lay beside it.

"Come, now, Mr. Marsh," he said, in a voice of well-assumed calmness, as he moved forwards. "You just lie down on the sofa and sniff some of this."

"Never. Let me out of this room. I am not your prisoner."

"You are my patient," answered the doctor firmly, as he moved nearer.

"I refuse to be treated like this. Let me out I say."

Without heeding Geoffrey Marsh's expostulations, Norcross moved nearer. Then suddenly he made a sign to the man who stood close beside him, and before Marsh could offer any resistance he found himself on his back, held as in a vice by the stalwart groom. As he spluttered angry remonstrances a sickly vapour seemed to half stifle him. Cold drops struck his face, filtered through the gauze mask held before him.

"Stop—let me go," he got out in a half choked voice.

"Look here, Mr. Marsh," was the doctor's response, "be advised by me. Breathe quickly. Do what I say. By God, you'll thank me afterwards."

The figure on the couch struggled still, but the iron-like hands of the groom held him fast. The overpowering sweet smell increased.

"You are going to sleep—sleep—sleep," came from the doctor with emphasis. "You will sleep and be well—well."

From the now confused brain came an echoing response: "Sleep—well; sleep—well—well—well."

And the doctor, as if urging a last thought into that tired out mind, poured forth words of hope, of health, of strength, watching as he spoke the man's face from which consciousness was gradually passing away. A few minutes later Norcross told his servant he could go. Then, drawing an easy chair to the head of the couch he took up his position for a prolonged vigil.

Geoffrey Marsh lay motionless beside him in a profound sleep.

VI.

The sun had risen on the morning of the first of December. Throughout the night Dr. Norcross had sat beside the sleeping man. Once or twice, tired out with the strain he had undergone, he had dropped off to sleep, but only for a brief space. Looking at the figure on the sofa, now breathing calmly, the doctor could smile triumphantly over superstition and morbid imagination. The man was alive, and living beyond the time laid down by his mysterious forebodings.

The doctor smiled triumphantly. He would awake soon, he thought, and then he must face facts. Facts and dates are convincing.

The man moved in his sleep. Dr. Norcross bent over him, and as he did so Geoffrey Marsh opened his eyes and looked round vaguely.

"Where—where am I?"

"On the sofa in the dining-room," was the reply.

"But how? Why? But—" he got no further. He put his hand across his eyes as though wiping away a mist. Then he looked once more steadily before him towards the clock on the mantelpiece. As the doctor followed the direction of his gaze the man murmured, "Five minutes past eight."

"Yes, on the morning of the first of December," said Norcross, quietly.

"*The first of December,*" said the other, slowly. Then he relapsed into silence. Who can say what were the workings of that man's brain as he lay there trying to grasp the situation? Succeeding the struggle of last night had come repose. The excited brain with its lurid imaginations had been suddenly switched off, as it were. An interval had taken place for the natural forces to recoup themselves. Coming out of the darkness into the light of day, Geoffrey Marsh was once more able to look at facts.

"Do you remember anything?" asked the doctor, at length.

"I seem to have had some horrible dream. Something about a grave and Death—my death."

"You thought you were going to die yesterday, and —didn't."

"Yes, yes; I remember," he answered, eagerly.

"You thought you must die on the last day of November, and yet here you are alive on December the first."

"Yes, indeed. What a strange idea it was. A delusion, I suppose."

"Exactly," said the doctor, taking hold of his hand and helping him to rise. "All a rotten delusion due to overwork, Mr. Marsh. Thank your lucky stars you came to see me on Tuesday, however. Well, we pulled you through. But mind—never again such a lapse from the straight path of common sense. Now, sir, let us toss up which of us has the bath first, for I am longing for my breakfast."

And suiting the action to the word, Dr. Norcross tossed a coin into the air.

FREDERIC VICARS.

Books recently added to the Wills Library.

By Purchase.

*Collected Papers by the Staff of St. Mary's Hospital, Mayo Clinic, Rochester, 1913, 1914.

Cowan's Diseases of the Heart, 1914.

Cunningham's Manual of Practical Anatomy, vol. I., 6th edition, 1914.

*Ergebnisse der Inneren Medizin und Kinderheilkunde, vol. 12, 1913.

Forel's Hypnotism, or Suggestion and Psychotherapy, 1906.

Gibson's Handbook for the Post-mortem Room, 1914.

Herringham's Kidney Diseases, with chapters on Renal Diseases in Pregnancy. By H. Williamson, 1912.

*Keen's Surgery, its principles and practice, vols. 1—6, 1906—1913.

Macewen's The Growth of Bone: Observations on Osteogenesis, 1912.

Mills and Humphreys' Text-book of Surgery for Dental Students, 1913.

Philip's Physical Chemistry, its bearing on Biology and Medicine, 1913.

Robertson's Manual of Medical Jurisprudence, Toxicology, and Public Health, 2nd edition, 1913.

Rolleston's Diseases of the Liver, Gall-bladder, and Bile Ducts, 2nd edition, 1912.

Taylor's Practice of Medicine, 10th edition, 1914.

Thomson's Diseases of the Nose and Throat, comprising affections of the Trachea and Œsophagus, 1912.

Walker's Surgical Diseases and Injuries of the Genito-Urinary Organs, 1914.

*For Davies-Colley Collection.

PRESENTED.

Aikin's The Voice, an introduction to practical phonology, 1910. By Dr. Aikin.

Bourne's Introduction to the study of the Comparative Anatomy of Animals, 2 vols., 1900—02. By Mr. H. F. G. Berncastle.

Bruce's The Harveian Oration on the Influence of Harvey's work in the development of the doctrine of infection and immunity, 1913. By Dr. J. Mitchell Bruce.

Collected Papers from the Department of Pathology in the University of Oxford, vol. 2, 1911—13. By Professor Dreyer.

Curry's Observations on Apparent Death from Drowning, Hanging, Suffocation by noxious vapours, Fainting-fits, Intoxication, Lightning, Exposure to cold, etc., and an account of the means to be employed for recovery, 2nd edit., 1815. By Dr. Hale White.

Fagge's Pocket Anatomy, 7th edition, 1914, 2 copies. By Mr. C. H. Fagge.

Goodhart and Still's Diseases of Children, 10th edit., 1913. By Sir James Goodhart.

Hurry's Ideals and Organisation of a Medical Society, 1913. By Dr. J. B. Hurry.

Journal of Physiology, as published. By Dr. A. F. Hertz.

Morris's Origin and Progress of Renal Surgery, 1898. By Mr. W. Wale.

Oertel's The anatomic histological processes of Bright's Disease, 1910. By Dr. Horst Oertel.

Pedley and Harrison's Our Teeth, how built up, how destroyed, how preserved, 1908. By Mr. R. D. Pedley.

Phelps's Mortality from Alcohol in the United States, 1912. By Mr. E. B. Phelps.

Phelps's Supposed Death-rates of Abstainers and non-Abstainers, and their lack of scientific value, 1913. By Mr. E. B. Phelps.

Practitioner, as published. By Dr. A. F. Hertz.

Thelwall's Essay towards a definition of animal vitality read at the Theatre, Guy's Hospital, January 26th, 1793; in which several of the opinions of the celebrated John Hunter are examined and controverted, 1793. By Dr. Hale White.

Wale's List of books by Guy's Men in the Wills Library, 1913. Large paper copy and specially illustrated edition, bound in whole morocco. A replica of the copy accepted by His Majesty King George. By Mr. W. Wale.

White's Materia Medica, etc., 13th edition, 1914. By Dr. Hale White.

PAPERS, ETC., RECEIVED.—Hospital, Nursing Times, Polyclinic, Prescriber, St. George's Hospital Gazette, Magazine of the London (Royal Free Hospital) School of Medicine for Women, St. Thomas's Hospital Gazette, St. Bartholomew's Hospital Journal.

Papers by Guy's Men.

A. H. G. Burton, M.D., D.P.H.: Difficulties in tuberculin administration (illustrated).—*Practitioner*, July, 1914.

H. Charles Cameron, M.D.: On Diathesis in Infancy; a plea for its closer study.—*British Medical Journal*, July 11th, 1914.

W. S. Handley, M.S. Lond., F.R.C.S.: A case of Cheilotomy.—*Lancet*, July 11th, 1914.

Major A. J. Hull: The transport of wounded in war.—*Journal Royal Army Medical Corps*, July, 1914.

W. Johnson, M.D. Lond.: A pathological investigation of four cases of pituitary tumour.—*Lancet*, July 4th, 1914.

Lawrie McGavin, F.R.C.S.: Four cases of ulceration of the face.—*Clinical Journal*, July 8th, 1914.

G. Newton Pitt, M.D., F.R.C.P.: Pyrexia of obscure origin (illustrated).—*Practitioner*, July, 1914.

Frank Shufflebotham, M.A., M.D. Cantab., J.P.: Abstracts of the Milroy Lectures on the hygienic aspect of the coal-mining industry in the United Kingdon; Lecture IV., Miners' Nystagmus.—*Lancet*, July 4th, 1914.

Major J. C. B. Statham: Report on a series of eight hundred and thirty-three medical pyrexias occurring in the Sierra Leone Garrison during the period October 4th, 1912, to October 4th, 1913, with remarks on the bearing of these diseases on the health of the troops.—*Journal Royal Army Medical Corps*, July, 1914.

Maxwell Telling, M.D., F.R.C.P.: A plea for the more systematic employment of treatment by suggestion.—*Practitioner*, July, 1914.

Change of Address.

C. Doswell Wallis, L.D.S., "Frome," 116, Portland Road, Worthing, Sussex.

Dr. A. Neville Cox, from 12, Burlington Street, Brighton, to 21, Cornwall Gardens, Preston Park, Brighton.

G. Vivian Dymott, L.D.S., from 1, New Road, Green Street Green, Orpington, to "St. Denys," 214, Lewisham High Road, S.E.

Dr. Chase, to "Sunnyside," 103, Newbold Road (opposite Gladstone Road), Chesterfield. (Telephone, 328.)

L. C. Cohen, to Rosedene, Terregles Street, Maxwelltown, Dumfries, N.B.

R. Cyril H. Francis, M.B., B.S., from Merton House, Ross, Herefordshire, to 12, St. Owen Street, Hereford.

O. R. L. Wilson, M.B., B.S., from Hampstead General Hospital, to Southwark Infirmary, East Dulwich Grove, S.E.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Appointments.

Naval and Military.

Capt. M. C. Wetherell, R.A.M.C., has been appointed to hold charge of the Military Hospital at Fethard.

Capt. H. F. Joynt, R.A.M.C., has been transferred from Cape Town to Wynberg.

Civil.

N. I. Spriggs, M.D. Lond., F.R.C.S. Eng., to be H.M. Certifying Factory Surgeon for Leicester (West).

University of London.

The following medical members of the Senate were appointed for the ensuing year:—

Academic Council: Mr. H. L. Eason.

Council for External Students: Dr. Frederick Taylor.

Dr. Frederick Taylor was elected Chairman of the Committee of Medical Members of the Senate.

Lawn Tennis.

JUNIOR INTER-HOSPITAL CUP TIES.

1st Round.—GUY'S v. ST. THOMAS'S.

On June 8th, at Perivale.

SINGLES.

J. Totton beat C. Isard	6–4, 6–3
N. Minns lost to C. Pink	3–6, 3–6
R. Sells beat H. Dawson	6–1, 6–2
K. M. Woodruff lost to R. Cooke	4–6, 5–7
A. K. Day-Lewis beat A. Usborne	6–4, 6–3
J. H. Parry beat Y. Eccles	6–1, 4–6, 6–4

DOUBLES.

Totton and Sells beat Isard and Dawson	6–1, 8–6
lost to Pink and Cooke	6–1, 6–8, 4–6
beat Eccles and Usborne	6–1, 6–2
Minns and Parry beat Isard and Dawson	6–4, 4–6, retired
lost to Pink and Cooke	6–4, 3–6, 2–6
beat Eccles and Usborne	7–5, 6–4
Day-Lewis and Woodruff beat Isard and Dawson	6–3, 5–7, 6–2
beat Pink and Cooke	7–5, retired
lost to Eccles and Usborne	6–4, 8–10, 4–6

RESULT.—Guy's won by 10 matches to 5.

2nd Round.—GUY'S v. ST. MARY'S.

On June 9th, at Honor Oak Park.

SINGLES.

J. Totton lost to A. R. Fuller	2–6, 2–6
R. Sells beat C. C. Keane	6–2, 13–11
N. Minns beat H. Gosse	8–10, 6–3, 6–2
A. K. Day-Lewis beat C. G. C. Varsdrey	6–1, 7–5
J. H. Parry beat W. Johnson	6–1, 1–6, 6–1
K. M. Woodruff beat W. D. Arthur	6–3, 7–5

DOUBLES.

Totton and Sells beat Fuller and Keane	7–5, 6–4
Minns and Parry beat Gosse and Varsdrey	10–8, 6–3
Day-Lewis and Woodruff beat Johnson and Arthur	6–4, 6–2

RESULT.—Guy's won by 8 matches to 1.

Semi-Final—GUY'S v. KING'S COLLEGE.

On June 10th, at Honor Oak Park.

SINGLES.

J. Totton lost to H. A. B. Whitelocke	5–7, 6–3, 2–6
R. Sells lost to K. Playfair	0–6, 1–6
N. Minns lost to H. L. Addison	4–6, 2–6
A. K. Day-Lewis lost to R. Goldsmith	3–6, 4–6
J. H. Parry beat A. S. Wakeley	6–3, 12–10
K. M. Woodruff beat W. A. Troup	4–6, 6–2, 6–3

DOUBLES.

Totton and Sells beat Whitelocke and Addison	0–6, 6–2, 6–3
beat Playfair and Goldsmith	6–2, 6–4
beat Wakeley and Troup	6–2, 6–3
Minns and Parry lost to Whitelocke and Addison	6–3, 3–6, 3–6
lost to Playfair and Goldsmith	4–6, 4–6
beat Wakeley and Troup	0–6, 6–0, 6–1
Day-Lewis and Woodruff lost to Whitelocke and Addison	7–5, 3–6, 7–9
lost to Playfair and Goldsmith	4–6, 4–6
beat Wakeley and Troup	7–3, 6–4

RESULT.—Guy's lost by 7 matches to 8, after a very close finish.

2nd VI.—GUY'S v. ROYAL DENTAL HOSPITAL.

On June 13th, at Honor Oak Park.

DOUBLES.

Day-Lewis and Sells beat Claremont and Greenish	6–4, 6–2
beat Packham and Yonge	6–1, 6–4
beat Winter and Speak	6–2, 6–0
Parry and Minns lost to Claremont and Greenish	4–6, 2–6
beat Packham and Yonge	3–6, 6–1, 6–4
beat Winter and Speak	6–3, 6–0
Stevens and Laver lost to Claremont and Greenish	3–6, 6–4, 3–6
beat Packham and Yonge	6–4, 6–1
beat Winter and Speak	6–2, 6–1

Guy's won by 7 matches to 2.

Cricket.

GUY'S v. WANDERERS.

Played at Honor Oak on June 27th.

GUY'S.

C. Vincent Brown, lbw, b Robinson	30
L. H. Dixon, c Neumeggen, b Robinson	39
A. C. M. Coxon, c Robinson, b Wells	12
D. M. Whitcombe, b Taylor	46
F. J. Biddle, not out	78
B. Sampson, b Taylor	0
J. R. Cox, c Forbes, b Taylor	17
C. G. Gibson, c Robinson, b Bradley	1
L. H. Gilbert, not out	33
H. M. Gray, E. S. Bowes, did not bat.	
Extras	28
Total (for 7 wickets)	284

WANDERERS.

Stanley Coleman, not out	70
G. Dawdrey, b Dixon	7
L. S. Wells, c & b Gray	25
R. W. Forbes, b Dixon	12
T. C. Stafford, not out	37
Robinson, Bradley, Neumeggen, Taylor did not bat.	
Extras	9
Total (for 3 wickets)	160

GUY'S v. GRANVILLE.

Played at Lee on July 1st. Dixon took 5 for 54, and Sampson 4 for 54.

GRANVILLE.

R. H. Ford, c Vincent Brown, b Sampson	2
F. Odell, c Vincent Brown, b Dixon	27
S. Platt, b Dixon	0
L. W. Barber, b Sampson	10
Col. Lowis, c Coxon, b Dixon	2
D. S. Lawrie, b Sampson	24
C. P. Barber, b Dixon	4
C. T. Stanham, b Sampson	4
C. E. Fysh, b Dixon	10
— King, not out	25
Extras	3
Total	111

GUY'S.

J. R. Cox, run out	40
C. G. Gibson, b L. Barber	12
G. P. Lindsay, b Lawrie	15
H. M. Gray, b L. Barber	46
C. Vincent Brown, b C. Barber	47
L. H. Dixon, c Ford, b C. Barber	32
B. Sampson, not out	45
A. C. M. Coxon, not out	28
L. H. Gilbert, H. Sterling-Hill, E. S. Bowes did not bat	
Extras	48
Total (for 6 wickets)	313

GUY'S v. PAST.

Played at Honor Oak on July 4th.

PAST.

R. Montgomery, lbw, b Dixon	8
F. Morres, c sub, b Sampson	65
Rev. Langdale, b Dixon	29
H. M. Langdale, b Dixon	23
M. M. Munden, c Sampson, b Coxon	67
J. Bookless, b Sampson	3
H. Lee, b Sheldon	25
C. H. Fagge, st Cox, b Dixon	21
Miller, b Coxon	3
Zamora, not out	8
F. D. Saner, b Coxon	7
Extras	13
Total	272

GUY'S.

J. R. Cox, b Munden	58
L. H. Gilbert, c Montgomery, b Munden	28
W. T. Sheldon, c Zamora, b Munden	22
L. H. Dixon, c Zamora, b Munden	3
J. G. Saner, did not bat.	
B. Sampson, b Montgomery	3
A. C. M. Coxon, b Munden	25
C. C. G. Gibson, b Saner	0
H. M. Gray, not out	29
H. C. Rook, not out	33
Extras	22
Total (for 7 wickets)	223

GUY'S v. FOREST HILL.

Played at Perry Hill on July 6th.

GUY'S.

L. H. Dixon, c Beetham, b Williams	4
C. Vincent Brown, b Beetham	6
B. Sampson, b Owens	75
T. W. Sheldon, c Beetham, b Williams	0
J. R. Cox, c Vining, b Owens	3
A. C. M. Coxon, c Wright, b Williams	38
F. J. Biddle, b Owens	37
H. M. Gray, b Owens	3
L. H. Gilbert, c Neall, b Owens	11
P. Lindsay, not out	40
C. C. Gibson, c Wright, b Harris	27
Extras	30
Total	274

FOREST HILL.

J. S. Owens, b Sampson	18
K. P. Neall, run out	32
R. J. O. Beetham, c Biddle, b Dixon	11
E. Mackin, b Dixon	3
W. R. Williams, c Gilbert, b Biddle	14
E. B. Nichols, c Sampson, b Dixon	7
S. Wright, not out	5
C. Moore, c Biddle, b Dixon	0
H. V. Harris, b Biddle	0
D. C. Vining, c Biddle, b Dixon	1
E. C. Ehee, c Sampson, b Biddle	0
Extras	20
Total	111

Births.

DEPREE.—On July 7th, at 65, Portland Court, W., to Lilian and Hubert Depree, a son.

LAYTON.—On July 5th, at 53, Acacia Road, N.W., the wife (formerly Sampson) of T. B. Layton, M.S., of a daughter (Eleanor Mary).

ZORAB.—On July 8th, at Carlton Crescent, Southampton, the wife of Arthur Zorab, of a son.

Marriages.

CANE—GUYOT.—On July 4th, at St. Martin's-in-the-Fields, Trafalgar Square, Lionel Charles William Cane, M.R.C.S., L.R.C.P., to Doris, eldest daughter of Mr. and Mrs. Guyot, of Belvedere, Kent.

HUNT—STUBBS.—On June 25th, at St. Gabriel's, Westminster, Edwin Guy Hunt, M.D., M.R.C.S., L.R.C.P., to Kate Millicent Stubbs.

ODGERS—HIGGINS.—On Tuesday, June 30th, at All Saints, Ennismore Gardens, by the Rev. W. E. Addis, M.A., Norman Blake Odgers, M.Ch., F.R.C.S., third son of the Rev. D. Odgers, of Oxford, to Mabel, youngest daughter of G. Randell Higgins, The Croft, Burcote-on-Thames, Oxon.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT is, of course, a common-place that of the three great medical services of the Crown, the Indian, the Army, and the Naval, the latter is by far the least popular. For the I.M.S., and for the Army also in recent years, since that service has been reformed, there are always at least three or four candidates for every vacancy. For the Naval Service, on the other hand, there are frequently not as many candidates as there are vacancies. As a result the Naval Medical Service is short of its full complement of 594 officers by about 70 men. This fact is evidence that there must be something very radically wrong with the service either as regards the work it can offer or the conditions under which the work must be done.

THE British Medical Association has recently enquired into the reasons for this shortage, and their findings are set out in an exhaustive report which has just been published. This report points out that, owing to the present-day concentration of the Fleet in home waters, the service has lost one of its most potent attractions as providing a pleasant and easy means of seeing the world. The life consists now, for most of the men, of monotonous cruises round the lonely parts of the British Isles. There has been no corresponding improvement to make up for the loss of this advantage.

The conditions of service in Army and Navy are contrasted and compared in their various aspects. From the statements in the report it is clear that the Naval Service is at a disability from almost every point of view, as regards rates of pay, length and conditions of leave, relations to executive and combatant officers, promotion, relative rank, pensions, etc., etc. In fact, from whatever aspect the question is approached, the Army Medical Service seems far more attractive than the Naval.

A CONDITION of affairs like this would be bad enough if the two Services were from the outset equal as regards the opportunities they offer for interesting work. But in reality the Naval Service starts under a great disadvantage as compared with its rival on land. It is clear that medical work can never be thoroughly satisfactory at sea, and that in the interests both of the patient and of the crew the sick should always be transferred to establishments on shore as soon as it is possible. This course seems to us inevitable, but it means that the naval surgeon has, except when he is attached to a hospital on shore, very little opportunity of fully treating and looking after his patients. This consideration alone would make the Navy less popular than the R.A.M.C. even if other conditions were equal. The combination of unsatisfactory work and bad conditions of service deter many men who for other reasons would be glad to join.

THERE is some reason to believe that the authorities at the Admiralty are exercising their minds over this question of shortage of medical officers, but it will be clear to any one who reads the report of the British Medical Association that as a preliminary the conditions of the Naval Service must be levelled up to those of the Army. Even equality of conditions will not, we think for the reason given above, make the R.N. as attractive as its sister services, and if the best men are wanted, as they should be in the Navy, extra opportunities for post-graduate work, for research and for specialisation must be granted.

THE list of successes at all the recent examinations is a large and very satisfactory one. We have to congratulate Messrs. H. Gardiner, H. Glendining, and A. H. Todd, on obtaining the M.S. (Lond.), and Messrs. R. Montgomery and H. L. Hopkins on their success in the M.D. examination. The M.S. result is particularly good. Five Guy's men sat for the examination (half the total number of entrants) and three passed. In the Final Conjoint also the pass list was very good. Eighteen men passed in medicine, 14 in surgery, and 23 in midwifery. The number of successes in midwifery represents a pass of over 75 per cent.

IN the Second M.B. (Lond.) examination, L. S. Debenham obtained distinction in all three subjects, and Joffé was distinguished in Physiology. We congratulate both men heartily. Six men passed in all three subjects and six in two out of three. Out of fifteen entrants for the Second Conjoint, nine passed. The School has every reason to be pleased with such good results all round.

THIS week has seen the surgical side of the Hospital given over to an American invasion. There have been literally hundreds of American surgeons here daily in connection with the Surgical Congress which was held in London during the week. Nearly all the surgical staff held clinics on two or more days and some of them almost daily. The visitors were all apparently very interested in the work they saw done and expressed themselves as being greatly impressed by the excellence of English Surgery. They were, of course, particularly anxious to see and hear Sir Arbuthnot Lane, and the Clinical Theatre was crammed to overflowing whenever he was at work.

In addition to the numerous operations during the week there were demonstrations in most of the special departments of selected cases, of modern methods of diagnosis, and of the after-result of certain operations. There was one very large collection of cases to illustrate the results of colectomy for chronic intestinal stasis.

THE lay press, of course, have had some account of the proceedings of the Congress from day to day. Most of them have been content to indicate briefly and vaguely the class of work which was being done, but one evening paper allowed its enthusiasm to outrun its knowledge one afternoon with ludicrous results. In the course of a short article containing several other "howlers," the following statement appeared: "Sir A. Lane has been showing how intestinal stasis (a stoppage of the blood) can be corrected by 'short circuiting' the intestines"!

MR. G. S. MILLER has been appointed Chief Clinical Assistant to the Throat and Ear Department (Mr. Layton), and Mr. A. Seabrooke has been appointed Obstetric Resident, his duties commencing on August 1st.

WE hear with very great regret that Mr. L. A. Dunn is seriously ill and was operated upon during the week. The operation was, we understand, quite successful, and he is, according to our latest information, progressing very satisfactorily. We offer him our sincere condolences on his ill-fortune, and hope that he will make a speedy recovery, and will be able before long to resume his work in the Hospital.

PAPERS, ETC., RECEIVED.—Clinical Journal, Light Car, Nursing Times, Hospital, M.S. Journal, Clinical Excerpts, London Hospital Gazette, St. Mary's Hospital Gazette, The Stethoscope.

Sixth International Dental Congress.

This Congress, which is being held in London from August 3rd to August 8th, is under the patronage of His Majesty the King, and is the first of the series to be held in this country. Previous Congresses have taken place at Paris in 1889, Chicago in 1893, Paris in 1900, St. Louis in 1904, and Berlin in 1909.

The work is, as is customary at such congresses, divided up into sections, each dealing with a special aspect of dental surgery. There are in all ten sections, which will cover the whole range of dentistry from dental anatomy and physiology to dental education.

Large numbers of foreign and American dental surgeons have already signified their intention of being present, and, of course, there will be a very large muster of British dentists in London during the week. The list of sectional officers shows how large a position is occupied in the dental world by the Guy's School. Almost every section has one or more Guy's men as officers.

The President of the Congress is Mr. J. Howard Mummery.

The social side of the Congress has not been neglected, and numerous schemes have been arranged for the entertainment of the visitors. Among the chief events are the following :—

The Congress will be opened by an informal reception at the Hotel Cecil on Monday, August 3rd. This reception will be preceded by a dinner for the officers of the Congress.

On Tuesday, August 4th, the Lord Mayor and Corporation will hold a reception for members at the Guildhall.

The President and Council of the Royal College of Surgeons hold a similar reception on Wednesday, August 5th, and in the evening of the same day the Government gives an official dinner (at which Sir Herbert Samuel will preside) at the Savoy Hotel.

On Thursday, August 6th, the Congress Banquet will be held at the White City.

On Friday, August 7th, there will be a Garden Party at Guy's from 4 to 7 p.m., and a reception by the British Dental Association in the evening at the Natural History Museum, South Kensington.

From the Hospital point of view the Garden Party on Friday, August 7th, is the most interesting event. As is customary on such occasions, the Medical and Dental Schools, the Library, the Museum, and the Wards, etc., will be open for inspection. A short illustrated account of the Dental School has been prepared for distribution to the guests.

Tickets for the Garden Party may be obtained by any Student, Medical or Dental, on application to the Medical School Office.

In Northern Rhodesia.

Life for some time had been strenuous! A practice embracing a Government appointment—entailing as an incidental duty the examination for sleeping sickness and vaccination of every native passing through the district—the medical officership of a copper mine situated at a distance of 5 miles, and 150 miles of railway, means a lot of travelling about under a tropical sun. True, a motor bicycle had eased the strain, but people in these parts have a knack of building on the tops of kopjies and other inaccessible places where it is necessary to tramp.

I was expecting my wife out from England shortly with a wonderful daughter whose acquaintance I was to make for the first time. I was trying to make the wilderness adjoining my house into a garden fair with roses and other choice blossoms to welcome them. This meant rising with the sun and endeavouring to circumvent the wily white ant and a thousand other Rhodesian pests. Some thoroughbred fowls—a recent purchase—were to furnish us with new-laid eggs. The blessed birds got every ailment under the sun, and kept me busy dipping them in antiseptics, swabbing out their mouths with glycerine and borax, and administering brandy and castor oil. Lest this falls into the hands of an expert, let me confess that I do not know even the first things about fowls.

What with these domestic duties and professional work, each night saw me early ready for bed, but for the last week we had had strangers within our gates —one no less a celebrity than a Guy's man on a shooting trip. I can count on the fingers of one hand the Guy's men I have been lucky enough to run across in the last twelve years out here.

Such a wonderful occurrence had led to a few late nights, for invitations had showered upon us, your Rhodesian being nothing if not hospitable. It was, then, with a thankful heart that I dosed one night on the magistrate's stoep under the pretence of listening for an approaching train while the others made music, the magistrate being the proud possessor of a piano, the first one in these parts where the ubiquitous gramophone usually serves. The train rolled up only about three hours late, and at midnight I boarded her for a railway trip, expecting to be absent about 24 hours. Some inspiration made me pack a clean suit amongst my kit. The following evening, Thursday, I reached Broken Hill. A telegram received there ordered me to proceed 300 miles further by train to hold an inquiry into the death of a native who had died after an assault by a white man. I arrived at a small wayside station just before dawn on Saturday morning, and at once mounted a borrowed bicycle, which was about two sizes too small for me, and rode off to the magistrate's house, distant 3 miles. It was a sorry trip; the capacity of the bicycle's inner tubes

was about three hundred yards, then I had to get off and pump. However, I did eventually reach the house, and was informed that the native's burial place was 40 miles away. I had to do this journey and be back on Monday to catch the mail train.

Carriers and a horse were at my disposal, so, after breakfast I purchased a few provisions and a piece of goat meat and by 10.30 was away. I had not ridden a horse any distance since the Boer war. I travelled till 1.30 and then halted for lunch. The day was blistering hot, and after lunch I lay down with the saddle for a pillow and dozed, waking with a start at 2.30. We were soon on the road again and travelled till dusk. It was the hottest time of the year and the sun literally scorched down on us. It was walk-march all the way; the pace had to be that of my carriers, and apart from all other reasons it was an arduous task to persuade the horse to break into a trot or gallop. The country through which I travelled was Rhodesia's choicest—fine open country of hill and vale dressed in its spring garb of dainty green. I saw plenty of small buck and a herd of waterbuck, but it was forced march and I had no time to shoot. By 7 o'clock I was camped and dining off very unpalatable goat meat and mouldy bread, for I made the melancholy discovery that all the bread purchased for the journey was mouldy. After dinner, trusting to luck for the morrow's food, I presented the remains of the ancient goat to my carriers.

I was up before dawn the next day, partaking of a frugal breakfast of bread and jam, and the east was just blushing a delicate pink as I mounted my sorry steed. We approached a native village soon after. The men saluted us by sitting on their haunches and clapping their hands, while the women uttered piercing cries, interrupting the sounds issuing from their mouths by covering them with their hands and uncovering at rapid intervals. It is astonishing the din the women can make by this process which, though now a formal greeting, in former days used to inform the village of the approach of strangers, possibly enemies.

At 10 a.m. I reached the Dutchman's farm to find all the occupants away, the house locked up and in charge of some filthy natives. I had to wait some time for my carriers to arrive with my provisions, and after five hours I was decidedly hungry. Thinking it would be more comfortable to wait inside the house than outside in the scorching sun, I reconnoitred and effected an entry through a kitchen swarming with flies. I found myself in a sitting-room, the windows and doors of which appeared to have been closed through long ages. The atmosphere was indescribable. I got a window open and sat down and looked around for something to read. The only literature I could see was a somewhat strange assortment—the Bible and the Winning Post Annual. I chose the latter, and as soon as my carriers arrived I proceeded to prepare breakfast and sat down with a wonderful appetite, but the flies scented food from afar and invaded the room in their hundreds of thousands; each mouthful was black with flies, and that and the atmosphere of the room finished me, and I was more nearly violently sick than during all the unpleasant tasks that were to follow. I fled to the stoep, but my appetite was gone, and my repast was very short.

At 12 noon, the hottest part of the day, I proceeded a mile to the grave. The body, which had been buried five weeks, was reached about four feet below the surface. During the disinterment we disturbed a huge rat, which jumped out of the grave and scampered away over the veldt. The natives with me could not speak the language of my district, so we did not understand each other very well. At this stage of the proceedings I sprinkled some eucalyptus oil on a piece of gauze and tied it over my mouth and nose. Later, when my hands were soiled, the eucalyptus became overpowering and I nearly choked. I signed to the natives to unloosen it; they, thinking that it was slipping, fastened it tighter than ever, and I was very unhappy till I managed to get it off. I will not dwell on the details of the post-mortem, which can safely be left to the imagination; that and the subsequent trial, I think, is sufficiently interesting for an article itself, suffice it to say that I decided death was due to pleurisy. It is the first dread plunge into a task of this sort that costs, but I shall never forget the myriads of biting flies that gathered round and drove me nearly mad, and the well-meant efforts of a native who attempted to drive them off and who first played his switch of leaves over the corpse and then gently stroked my face!

At 2 p.m. I started back to my camp. Again it was blazing hot, but about 4 it commenced to rain, and I was soon wet through and shivering with cold. As I passed through the village in the early morning I had purchased some eggs and a fowl which I had sent back to my camp for the boy to cook for dinner. Through the long weary hours of my ride home, hungry and wet, my mind dwelt pleasantly on the prospect of that roast fowl. I watched the sun go down, and then rode on in the night till 8 o'clock, when I saw through the bush the welcome gleam of my camp fires.

I was soon ready for dinner and demanded cheerfully the roast fowl. My boy proudly produced the live bird from the side of the tent. I demanded, "What the, etc.," which elicited the reply that he thought I wanted to take it to Ndola to lay eggs. Mere words would not suffice. I demanded whisky, but even that was not forthcoming. As usual, the most important carrier, and the one with the lightest load—my luncheon basket, was the one carrier who had lingered behind. There was nothing for it but to take a book and await developments. Eventually the dawdler appeared, and I enjoyed my long-delayed sundowner, and in an incredibly short time the

slaughtered and dismembered bird, really appetisingly cooked, made its appearance, and I fell to with a good appetite. Meantime a most offensive odour began to pervade the tent, which I traced to my post-mortem gloves carefully placed, of course, on my pyjamas!

Next morning I reached the railway again after a five hours' ride, having done 80 miles in 48 hours, and, for obvious reasons, I was not very keen on sitting down. Having breakfasted at the hotel and purchased new underclothing at the local Jew's store, I proceeded to my coach and, with the help of a bucket of water, got very nearly clean again. Then, arrayed in a clean linen suit, shaven and washed, I felt myself once more. Travel for days in a dusty train, ride 80 miles under a broiling sun, without a change of clothes, then you will appreciate the real luxury of a shave and clean things. Spend ten hours in the saddle or on foot under a tropical sun tramping the veldt, and then, your boots removed, settle yourself in your deck chair in front of the camp fire and call for your whisky and sparklet—then, and not till then, will you realise just what nectar for the gods the Rhodesian's sundowner may be.

I now thought I would soak my post-mortem gloves in some lysol. I looked about for them, but failed to discover them. I called my boy to ask him where he had put them, although, even as I did so, an inspiration as to their whereabouts came to me. As I feared, he went straight to my luncheon basket and proudly produced them!

I dined very luxuriously in the dining car of the train that night, travelled all next day, and arrived back at my own station at 3.30 a.m. on Wednesday, having been away just a week. After breakfast the magistrate greeted me with the news he wished me to go another 35 miles out into the district to dig up another corpse, who was supposed to have died as the result of an assault. After a week's absence there was no end of work waiting, and to meet my wife as arranged at Buluwayo I was bound to catch a train on Sunday, being also subpœnaed to attend court to give evidence in the last case en route. I had calculated that I should just do it; now I learnt that a 70-mile journey was to be thrown in. I set to work at once, and after two days' most strenuous work, left at dawn on Friday for the second post-mortem.

I need not describe the difficulties of the journey there, suffice it that owing to my bicycle breaking I had to walk most of the way, first under a broiling sun and then in a raging thunderstorm. However, I finally reached the mission where I was to stay for the night, and spent a rather miserable night, being too tired and sore to sleep with comfort.

I rose at daybreak and proceeded to interview the chief whom I had sent for the night before. He was an old man with a grey head and beard and a wrinkled cunning face which at will he converted into an expressionless mask; a man who, nevertheless, had inherited from remote ages an air of chieftainship and dignity. The interview commenced. I explained the situation. One of his subjects after a beer drink had had words with another native who smote him over the head with a piece of wood lying handy; the injured native walked thirty-five miles to the magistrate to lay his complaint and the smiter was sentenced to two months' hard. The injured man returned to his village and a week or two after died, his face and neck having become greatly swollen. The relatives were not satisfied justice had been done, consequently I had been sent out to examine the body and ascertain the cause of death.

Where was the body buried? The chief smiled sweetly; he was sorry but he did not know. Where were the people who had buried the body? Again the polite smile. They were away working. Was there no one to show me the grave? Again the pleasant smile. Those that did know were too frightened to tell; the others would be angry. I pointed out that he was a chief and surely not afraid of his subjects. Again that meaningless smile. By this time I was getting angry; it looked like absolute defiance. I explained I was sent out by the great white man of the district and that he must know that the orders he gave must be obeyed. Once again he smiled and shrugged his shoulders as if to say the white man was foolishly persistent about an unpleasant subject; why not let it drop and talk of pleasanter things. I pointed out that if I did not receive his immediate assistance I should be under the painful necessity of tying him up and taking him to Ndola to be put in prison. He replied shortly, "Kill me if you like." The interview lasted an hour and a half. In the end it appeared I was beaten, a humiliating experience to be absolutely defied by a native. There seemed nothing for it but a journey home, my work not accomplished. I turned to my messenger, a uniformed Government servant, and remarked, "Tie him up," and proceeded to breakfast, feeling very cheap indeed. While we were sitting at breakfast the unexpected happened. A native appeared and volunteered to show me the grave in order to save his chief the indignity of being tied up. So that difficulty vanished.

I foresaw others: that the local natives in their present state of terror would assist me to dig up the corpse was useless to expect. I had grave doubts of the two carriers who had come ahead of us with my instruments, etc.; when we set out they asked anxiously what the picks and shovels were for, I replied in the classical terms, "Wait and see." I took along the chief who could not see why he should not be released at once. I assured him I would do so when my task was finished, but not till then. I expected to find the grave quite near, but we walked through untracked forest and vlei for a solid hour before we reached it, and a more beautiful spot for a grave no man could wish. He was taking his last rest in glorious open vlei, far from the haunts of men under the shade of a group of trees, and I could imagine no more peaceful spot. Now for the exhumation. I knew that I could lead where I could not drive, so I took

the first spell with the messenger. To my great relief the two carriers took their turn without a murmur, and I knew the worst was over. The corpse was well buried. For the first two feet all went well, but as we got deeper the task became more unpleasant, and one native showed signs of not liking it. As we got still deeper his distress became greater, distress not physical but mental; evil spirits hovered round him, he perspired profusely, trembled from head to foot, and I never saw mortal terror depicted on a man's face so plainly before. His b'oodshot eyes, with widely dilated pupils literally bulged from his head, and we dragged him out of the grave just in time, as he collapsed by the side and never moved again till our work was completed. I knew the remaining man would soon follow suit if I gave him the chance so I jumped down into the grave and did another spell myself. The corpse was not buried at the bottom of the grave but in a recess hollowed out in one side.

When we got to this I climbed down, dragged it out of the recess, and fixed some native rope round the body wrapped in the blanket just as it was and we soon hauled it to the surface. It was just falling to pieces as it had been buried five weeks. When I examined the body I found the head missing, it had remained behind in the grave. I soon retrieved that, and it took me a very little time to ascertain there was no fracture of the skull, and I believe my theory of septic trouble arising in the scalp wound was the correct one. The body was soon buried again, and I went to the place where I had left the chief and with some ceremony untied him. The journey back was pleasanter than before, our faces were homeward bound and the feeling of having carried out a difficult task in the face of odds is always a comforting one.

It was 1 p.m. when we reached the mission. I had thirty-five miles to travel, a lot of patients to see, and a train to catch the next evening. My feet were hopelessly gone in, so there was nothing for it but a machila and carriers. It was on the way home that one saw the best side of the native. We did not leave till 3 o'clock, but I wanted to camp at a place twenty miles away. After about seven miles we reached a village, and the carriers pointed out this was a simply splendid place for a camp, and that the other place was distant, and to reach it we must travel far into the night. However, seeing I was determined on they went, singing and laughing, and making a good six miles an hour. Then they came and humbly begged tobacco; my pouch was getting empty, and there was likely to be a tobacco famine, but the poor devils were doing their best so I shared it; their half was not much amongst them all, but their cheerful grinning faces as they squatted on their haunches, and clapped their hands in thanks were a study. After that the way was merry with song, and they wandered far into the forest in search of native fruit, which they poured into my machila, and which was very grateful to my tormenting thirst. By 7 o'clock we reached the village, the whole crowd as happy as sand-boys, and what a pleasure it is to travel with happy carriers. I was home next morning at 10 o'clock, a bath and a shave, and then breakfast with a glorious appetite. The motor-bike took me through the day's work by dusk.

It was with a great sigh of relief that I took my seat in the train that night, en route to meet my wife and the wonderful daughter. There would be no wilderness blooming with flowers to greet them on arrival, 'tis true, as during my absence the white ants had done their wicked worst, and the garden boy had had a most glorious slack, but that was a minor detail. After the turmoil and rush of the past week, the miles travelled, the post-mortems on two five-weeks' buried corpses, and a lot of professional work, the prospect of two days' complete rest in the train was delightful, let alone the fact that I was on my way to meet my wife after a long separation and the wonderful daughter who, by the way, insisted on an introduction to this world by no less a celebrity in the Guy's world than "Tommy." With a father a Guy's man, a mother the daughter of a Guy's man, a brother called Horrocks after an illustrious godfather, not to mention numerous uncles and aunts, all of Guy's, she could in reason demand no less. P. H. W.

Appointments.

Civil.

C. A. D. Bryan, M.R.C.S., L.R.C.P. Lond., has been appointed Certifying Surgeon under the Factory and Workshops Acts for the East Leicester District of the County of Leicester.

Dr. Ray Edridge has been appointed Assistant Anæsthetist to the Royal United Hospital, Bath.

Percival P. Cole, F.R.C.S., appointed Assistant Surgeon to the Cancer Hospital.

Military.

Captain H. C. Keates, I.M.S., is appointed Civil Surgeon, Multan, *vice* Major M. Corry, I.M.S., transferred.

Lieut.-Col. E. M. Pilcher, R.A.M.C., has taken up duty as Professor of Military Surgery at the Royal Army Medical College, Grosvenor Road.

Major J. C. B. Statham, R.A.M.C., has been transferred from the London District to the Sierra Leone Protectorate.

An exchange on the roster for foreign service abroad has been approved between Capt. H. O. M. Beadnell, R.A.M.C., and Capt. A. C. Osborn, R.A.M.C.

Capt. W. H. S. Burney, R.A.M.C., has been appointed to Ferozepore.

National Reserve.

Dr. G. W. C. Hollist has been appointed Adjutant of the Windsor Battalion, to date from June 26th.

Royal College of Surgeons of England.

Appointment of Lecturers.

The following appointment was made:—Hunterian Professor: W. Sampson Handley.

The Acute Abdomen.

CLINICAL LECTURE BY E. C. HUGHES.

Gentlemen,—By an acute abdomen is meant some serious abdominal catastrophe, *e.g.*, a perforation of a viscus or an intestinal obstruction, needing immediate operation.

It is extremely important, when meeting with such a condition, not only to make a correct diagnosis, but also to make it at the onset of the symptoms, so that you can at once proceed to deal with the illness, whatever it may be, and in whatever way may be necessary. The diagnosis, as a rule, becomes more and more obvious the longer the disease has been in progress, but in the acute abdomens, the majority of which need immediate operation, the prognosis becomes worse, the longer operation is delayed.

You must not imagine that the diagnosis does not matter, and that you may operate and make your diagnosis from your findings at the operation, for there are many conditions which may simulate an acute abdomen in their initial symptoms, but are due to disease of organs outside the abdomen, *e.g.*, a lobar pneumonia, uræmia, gastric crisis of tabes; and there are other conditions due to abdominal disease which do not require operation—intestinal colic, lead colic, ptomaine poisoning, etc., and others, again, due to intra-abdominal trouble which may not require immediate operation, *e.g.*, biliary and renal colic.

These are a few only of the diseases which may originate with symptoms characteristic of an acute abdomen, and it behoves you to go warily before arriving at your diagnosis. You can only arrive at the correct, or the approximately correct, diagnosis by careful examination, and by deductions from the history, and the various signs and symptoms observed.

The initial symptoms of an acute abdomen are three in number, abdominal pain, shock, and vomiting; and I am going to ask you to imagine that we have a patient here who has suddenly been seized with these symptoms, and we will proceed to examine him in the way which will help us to draw correct conclusions.

Pain.—The pain in an acute abdomen is at first referred to the umbilicus and central part of the abdomen, but later on to that part of the abdominal wall which overlies the damaged viscus. The pain of an appendicitis is at first referred to the umbilicus, and later to the right iliac fossa; that of a duodenal ulcer to the epigastric region to the right of the mid-line; of a gastric ulcer to the left, &c.

Shock.—The shock may be so excessive that the patient may die from it, or so slight that it may pass unnoticed.

Vomiting.—This symptom, too, may be slight or severe, but as a rule there are one or two acts of vomiting of gastric contents, followed by a pause. I shall refer to this again later.

Now let us look at the patient's face; if the abdominal pain is intense he will have an anxious expression, and if the symptoms have been in progress some time, he will have a typical abdominal face, sunken eyes with dark circles about them, a pinched face, and a livid colour. But if the pain be not severe, or if he be observed in the intervals between paroxysms of pain, the expression will be placid. If the temperature be raised, there may be a flush on the cheeks.

As a rule the pain is continuous in peritoneal inflammations or irritations, *e.g.*, a perforated viscus, and intermittent in an obstruction. The temperature is raised in an initial inflammation affection in the appendix or other viscus, but not in an intestinal obstruction, nor in a perforated gastric ulcer until inflammatory products have been formed, and are being absorbed.

The respirations may be increased in rate, the alæ nasi working briskly; this may be due to distension of the abdomen increasing the necessity for rapid respiration, to a simultaneous disease in the chest and abdomen, or to a respiratory disease, *e.g.*, pneumonia beginning with marked abdominal symptoms. Then, again, there may be extreme pallor of the face, so marked that it may be difficult to differentiate between the mucous membranes of the lips and the surrounding skin. This pallor in a woman may suggest the loss of a large quantity of blood, the result of a ruptured ectopic gestation.

Then with regard to the position and general appearance of the patient, he may be lying flat on his back with the hips and knees slightly flexed, the common position for a patient with extensive peritoneal inflammation, or he may be restless, throwing himself about in his bed, writhing with pain, and such symptoms are present when involuntary muscle is working against an insuperable obstruction, *e.g.*, in intestinal obstruction, or biliary and renal colic. A woman suffering from a ruptured ectopic gestation, who has lost a great deal of blood, is very restless, and this restlessness, the marked pallor, and sighing respiration, are three most important symptoms, and indicate that a large amount of blood has been lost.

Now let us pass on to the abdomen, and here we may find marks produced by applications for the relief of pain. The skin may be actually blistered, so hot have the applications been. We look, too, for the scars of previous operations; the importance of their presence is that the acute abdomen may be due to some adventitious peritoneal band or adhesion obstructing a coil of intestine.

Before making any other observation, we must rapidly examine the femoral and inguinal regions, so that the question of a strangulated hernia can be at once put out of court. A small strangulated hernia, particularly of the femoral type, has been time and time again overlooked, and the abdomen opened before the real cause of the trouble was found. And in some anomalous cases we may find a hernia present, but not suggesting by its characters that it may be the cause of the obstruction. It may feel soft and slack, but I believe that when one is present it should always be cut on first before proceeding to the abdomen, because, as a rule, it will be the cause of the obstruction.

Having made certain that no external hernia is present, let us proceed to look at the abdomen. First, with regard to distension. All stages between retraction and extreme distension may be met with. In the early stages of an obstruction or a peritonitis, the normal is not much departed from, but towards the later stages there may be extreme distension. In small intestine obstruction, if high up, it appears late and is not marked, but if large intestine it is early and marked. Further, when the large intestine is obstructed in its distal part, the flanks, as well as the central parts of the abdomen, are distended, while with small intestine obstruction the distension of the flanks is absent. In peritonitis, as a rule, the distension is not extreme unless the case is far advanced, and there are other signs then, immobility and rigidity, which point to the correct diagnosis.

Apart from this general distension there may be a local prominence of the abdominal wall, when an ovarian cyst, whose presence has not been suspected, suddenly undergoes torsion, and causes an acute abdomen. The cyst then becomes larger and tense, and if not in the pelvis will be detected as a visible, or if not visible, as an easily palpable lump in some part of the abdomen. We may see peristaltic movements of the intestines, but perhaps it is hardly fair to bring such cases under the heading of an acute abdomen, as it takes some time before the intestines can hypertrophy to such an extent as to be obvious through the abdominal wall. But still there are many essentially chronic abdominal diseases, *e.g.*, growths of the large intestine, which present themselves to our notice as acute intestinal obstructions.

Then with regard to rigidity and immobility, again the normal may not be departed from, the abdominal wall being supple and moving with respiration; and it is particularly in an obstruction with no involvement of the parietal peritoneum that the abdominal wall is normal, except for any distension that may be present. Now in peritonitis, whether local or general, there is a limitation of abdominal respiration, in part or altogether, and the abdominal muscles overlying the damaged part are rigid. This rigidity and immobility are due to the effort to prevent any friction of inflamed or damaged coils of gut on one another, and the parietal peritoneum. These two signs are very well seen in cases of a perforated gastric ulcer, where the patient has, shortly before his perforation, had a large meal and then ejected it into the general peritoneal cavity. Here the abdomen is at once flat, absolutely immobile, and as rigid as a board.

Percussion of the abdomen will detect any abnormal dull areas, *e.g.*, a distended bladder or an ovarian cyst, but I use it chiefly to detect two points—(1) the presence of free fluid, as shown by the shifting dulness with changes of the patient's position, and (2) the presence of free gas in the abdominal cavity, as shown by the early and absolute disappearance of the liver dulness. This latter sign is of great importance, but only where there is not much distension of the abdomen. For when there is much distension, the intestines crowd out the liver and may prevent it from coming in contact with the abdominal wall.

With regard to free fluid, whenever a viscus ruptures, the peritoneum is irritated, and as a result it pours out a copious fluid exudate; and at the operation this is seen by the enormous amount of fluid which escapes from the abdominal cavity—a far greater amount than could have come from the viscus itself.

Unfortunately, the presence of free fluid is not evidence that we are dealing with a perforation, for any irritation of the peritoneum will cause this profuse outpouring of fluid. Now a considerable proportion of obstructions are caused by peritoneal bands or adhesions, and these bands tie down a loop of bowel and obstruct it, and in so doing cause by their tight pressure intense irritation, with the result that a quantity of fluid is poured out, as is shown by the shifting dulness.

This is an important sign in the diagnosis of the cause of obstruction, and if I meet with a case in a young adult, who is unlikely to have a malignant growth, and find free fluid, I confidently expect the case to be obstruction by a band, provided that tubercular peritonitis can be excluded, and operation generally proves it to be the correct diagnosis. This copious outpouring of fluid is well seen in operations for strangulated femoral hernia, where, after dealing with the cause of the obstruction and reducing the bowel, a quantity of clear or blood-stained fluid may well up into the wound. Dressers assisting me at the operation have felt certain that I had opened the bladder, and only by soaking a sponge in the fluid and showing the absence of bubbling on adding sodium hypobromite, have I been able to convince them it was peritoneal fluid and not urine.

Free fluid is very likely to be present in malignant and tuberculous peritonitis, which not infrequently may begin as an acute abdomen.

Constipation.—In peritonitis, if at all extensive, the intestines suffer from a gradually increasing paralytic distension, so that in spite of drugs and enemata, no fæces nor flatus may be passed, and in severe cases enemata may be retained, a sign of bad prognosis. Pelvic peritonitis, however, and peritonitis due to the pneumococcus may be accompanied by diarrhœa. Now in obstruction the bowel above is contracting actively in its efforts to overcome the obstruction, while below it is contracted and collapsed. The effect of an enema is frequently to produce an apparently normal action, for it empties the bowel below the obstruction, the gut not being paralysed. If the possibility of this occurrence be forgotten, a mistake may be made. A further enema would produce no result, and afterwards no flatus nor fæces would be passed.

Vomiting.—I mentioned this as one of the three initial signs of an acute abdomen. After the initial vomiting there is a pause, after which the vomiting may or may not begin again with progressive inflammation of the peritoneal cavity; the vomiting becomes frequent and effortless, at first gastric in character, and then biliary; it does not commonly become fæcal. While with obstruction there is the initial vomiting followed by a pause, after which it begins again, sooner or later becoming fæcal. The higher the site of obstruction is in the intestine, the sooner does the vomit become fæcal.

Influence on Respiration.—Distension of the abdomen causes pressure on and embarasses the diaphragm, and so the respiration will be mainly thoracic, and will be shallow and more rapid than normal. The diaphragm, if its peritoneal surface be inflamed or irritated from any cause whatever, *e.g.*, a perforated gastric ulcer, will be thrown out of action in the same way as the abdominal muscles. If only one half is affected that half will not move so freely as normally, and it is probably on this account that the occasional difficulty in diagnosis arises between a lobar pneumonia and a perforated gastric ulcer.

Rectal and vaginal examinations made in the routine examination may reveal nothing or a great deal. If secondary to any disease of the female organs, inflammatory masses or tumours may be felt. In general or pelvic peritonitis, or blood in the peritoneal cavity, there will be great pain when the pelvic peritoneum is pressed upon. A nodule of new growth may be felt in the pouch of Douglas, and may suggest the acute abdomen is secondary to a growth of the intestine, with dissemination in the peritoneal cavity. A gall stone or a growth may be felt. When the examining finger is withdrawn from the rectum, it may have on it some altered blood or some abnormal material. The vaginal examination may detect a growth, a copious purulent discharge, or in the case of a ruptured ectopic gestation, dark blood.

Pulse Rate.—This is of extreme importance, not so much from the diagnostic point of view, but as an indicator to the progress of the disease. In any doubtful acute abdomen, when the question arises as to whether we are dealing with a colic or something more serious, half-hourly observations of the pulse rate should be taken, and a gradually increasing pulse rate will indicate that something more serious than a colic is the cause of the acute symptoms.

A Rise of Temperature is only of moderate importance at the onset of acute symptoms, for initial inflammatory affections only, *e.g.*, appendicitis cause a rise, and as a rule of moderate amount. There is one disease which does show itself by a high temperature, about 104° F., and that is pneumococcal peritonitis, and it is this high temperature which assists in distinguishing it from a severe appendicitis. In the more severe types of acute hæmorrhagic pancreatitis, the temperature remains subnormal throughout.

Urine.—The urine should invariably be carefully examined, and if none has been passed and cannot be passed, a catheter should be used to empty the bladder. Perhaps there is no urine in the bladder, and if so it may suggest suppression of urine, the acute abdomen being

simulated by uræmia beginning with abdominal symptoms. Inability to pass urine may be due to an inflamed organ in close proximity to the bladder, reflexly inhibiting it. After symptoms of an acute abdomen have been in progress some time, very little urine may be passed, because of the great loss of fluid by vomiting and in other ways.

Then examine the mouth, particularly to see if the blue line, indicative of lead poisoning, is present. For lead colic is the disease which is most frequently mistaken for an acute abdomen, and vice versa. Then carefully examine the lungs, and finally test the knee jerks, and the pupil reaction to light, so that the gastric crisis of tabes may not be overlooked.

Age.—At certain ages, certain diseases are common.

A. *Obstructions.*—Intussusception from six months to three years; strangulation by bands, 15 to 30 years; volvulus in old people; gall-stone obstruction in elderly fat females; growths in elderly people.

B. *Inflammations.*—Perforated gastric ulcer, 20 to 40 years; perforated duodenal ulcers in males of 30 years; appendicitis in children and adults up to 30 years; ruptured ectopic gestation, 24 to 30 years; inflamed female pelvic viscera in the child-bearing period; diverticulitis in fat subjects of middle age; pneumococcal peritonitis in children and young adults.

Previous history.—In many cases there will be nothing unusual, the patient having been in perfect health up to the moment of the illness. With perforation of gastric or duodenal ulcers there is, in the majority of cases, a history of preceding indigestion, perhaps of short duration or of some months, and very frequently of the symptoms typical of such an ulcer.

But remember that indigestion is very common, particularly in anæmic young women, and I have twice seen the history of indigestion point to a perforated gastric ulcer as the cause of the acute abdomen, whereas operation showed it to be due to a ruptured ectopic gestation. In these cases the difficulties are increased because many anæmic young women have irregular menstrual periods which may help to confuse the diagnosis.

Some cases of perforated duodenal ulcer are mistaken for appendicitis; the explanation is that the duodenal fluid is led into the right iliac fossa along the ascending colon, and causes symptoms of peritoneal inflammation in the right iliac fossa. In other cases it is not at all clear which organ is at fault, and a previous history of indigestion of the typical duodenal type may put us on the right track.

With appendicitis, whose first symptoms as an acute abdomen are due to the involvement of the peritoneum, there is often a history of indefinite ill-health, and I suppose during that time toxins are being absorbed from the inflamed mucous membrane. But more often we shall hear that there have been previously one or more attacks of abdominal pain, which the patients themselves may have disregarded or considered to be a bilious attack or ptomaine poisoning.

This leads us on to that type of case where symptoms appear shortly after a large indigestible meal, and the question arises whether we are dealing with an acute gastritis, a ptomaine poisoning, a perforation of a gastric ulcer, or an appendicitis. In some cases two or more members of a family have had similar symptoms, as in a case where a husband and wife had a meal of steak and kidney pie, both were seized with acute abdominal pain; the man was admitted and operated on for an acute appendicitis, and a gangrenous appendix was removed, while the woman never came under treatment at all, her symptoms rapidly subsiding.

I have seen many cases of acute appendicitis where the patients have assigned as the cause of their illness some apparent indiscretion in diet.

Then there is the question of a slight injury; a boy fell off a chair and apparently did not hurt himself, but in a few hours he developed an acute abdomen, and was found to have an acute appendicitis.

Returning again to indigestion: in elderly patients who are operated on for an intestinal obstruction, due to a growth of the large intestine, there is a frequent history of indigestion for some months preceding the obstruction. There may have been occasional vomiting and pain, but these symptoms are due to a gradually developing obstruction in the bowel.

And again with gall-stones: as a rule there have been symptoms for many years of some type of indigestion, *e.g.*, a flatulent dyspepsia, the symptoms being in reality due to gall stones; and though stout females do not have the monopoly of gall-stones, they enjoy, I believe, the monopoly of intestinal obstruction due to the impaction of a stone in the small intestine. The patient may have lost weight in the preceding months, and this may point to tubercle, malignant disease, or chronic indigestion. In women we shall inquire for any menstrual irregularity which may indicate a ruptured

ectopic gestation, or for profuse and more frequent periods, which may point to some pelvic inflammation, or for any purulent vaginal discharge.

We shall want to know if there has been any abnormality in the appearance or shape of the motions, and particularly if blood has been passed.

In infants, it is sometimes very difficult to say whether the acute symptoms are due to an acute colitis or to an intussusception, the difficulty arising when no abdominal tumour can be detected. Inspection of the motions, will, as a rule, differentiate between the two conditions.

Both are blood-stained and contain mucus; the motion of acute colitis, however, contains fæcal material, while that of intussusception contains none.

There are not many conditions where a quantity of blood is passed, the only common one being malignant ulceration of the rectum; I am excluding typhoid fever, which sometimes assumes the picture of an acute abdomen. A rare type is a thrombosis of the mesenteric vein, where a large quantity of blood is passed per anum, and it is only by this passage of blood that we can hope to diagnose this condition.

I do not think enquiries into the patient's occupation will help us, for we may find he is a worker in lead, and we shall be at once prejudiced in favour of lead colic.

Finally, it is only the careful consideration of the symptoms, the previous history, and the history of the attack, together with a routine examination of the organs, which will prevent our making mistakes in dealing with an acute abdomen, and when we meet with an anomalous case we must be careful to bear in mind the possibility of tubercular or malignant disease.

Change of Address.

Dr. A. H. B. Kirkman, from Queenstown, Cape Colony, South Africa, to Staplehurst, Kent.

Captain R. G Anderson's service in the Egyptian Army ends on October 31st, 1914, and after July 15th his address will be c/o Holt & Co., 3, Whitehall Place, London, W.

H. Gardiner, M.S, F.R.C.S., from 3, Rotherwick Crescent, Golder's Green, N.W., to 60, Rotherwick Road, Golder's Green, N.W.

Dr. Francis Richmond, from Beechurst, East Dereham, to Wickham Lodge, Aylesford, Kent.

Regeneration of Phalanx.

By EDWARD W. H. SHENTON.

The patient, a medical man, aged 45, crushed the pulpy palmar aspect of the right thumb in the hinge of a motor tool bag on February 4th. The crush was a severe one, and a small open wound was inflicted. There was considerable pain and a little bleeding; the nail was uninjured; no immediate treatment was adopted.

The patient was attending at the time a case of whitlow with suppuration and sloughing. He dressed this case three days before, and also the day after, but not on the day of the accident. The patient did his work for three days after the accident, though the thumb was rather swollen and painful.

On the evening of February 6th the pain became very severe, and the patient was seen by a brother practitioner. No fluctuation could be detected. The thumb was cleansed with ether soap and a cyanide gauze dressing applied.

On February 7th the pain was so severe that the patient had great difficulty in doing his morning's work, and in the afternoon his temperature was 100·4. He was seen that afternoon by a surgeon, but no fluctuation could be detected, and no opening was made. Hot boracic fomentations and Bier's vacuum pump treatment were tried, but both increased the pain and throbbing so intensely that they had to be given up. Cold evaporating lead lotion was the only thing that gave any relief, and the patient could get no sleep at nights in spite of opiates. The temperature remained between 99° and 100° for another two days.

On February 9th, though there was still no fluctuation, the palmar surface of the thumb was opened by a transverse incision parallel with the free edge of the nail, beads of pus escaped along the line of incision, and part of the pulp of the thumb was exposed as a vascular, red-grey slough, intensely tender, and fixed to the deeper parts. Frequent irrigation with weak peroxide of hydrogen was employed. Little or no relief was experienced after this, and the suffering was very severe. The temperature ran between 99° and 100°. There was a little redness on the dorsal aspect of the thumb, but it did not extend above the wrist. There were no enlarged or tender glands in the bend of the elbow or in the axilla. The thumb was considerably swollen, though not enormously so, very tense and sausage-shaped, and the throbbing pain was well-nigh intolerable, much the worst pain the patient had ever experienced.

On the evening of February 15th "continuous gas" was administered, and a vertical incision made on the palmar aspect of the thumb, meeting and just crossing

the previous transverse incision. More grey sloughing was exposed, but this also was fixed and could not be removed. The now crucial wound gaped widely, and after this the patient experienced the first relief of his symptoms. After he recovered from the gas, morphia gr. $\frac{1}{4}$ was given hyperdermically, and he got the first real sleep he had had for ten nights. Cold lead lotion dressings and frequent bathing with peroxide of hydrogen solution were continued. The patient's temperature for the next two days ran between 100·2° and 100·4°.

From February 19th to the 26th it ran between 99° and 100°. Pus from the sloughing wound examined on February 23rd showed the presence of staphylococcus pyogenes aureus unmixed with other organisms.

On February 26th some large sloughs were removed from under each flap of the wound, leaving a small slough in the centre, apparently over the tip of the phalanx, but probing in this region was so intensely painful that it could not be tolerated, and bare bone was not then detected.

On March 1st, after the usual peroxide irrigation, the patient could feel rough bone under the small central slough, which he had removed. He grasped this with forceps and pulled out the necrosed portion of the phalanx like a tooth. The removed portion proved to be the whole of the tip, and a considerable part of the shaft of the phalanx, the bone, when washed free from pus, proving to be etiolated and cobwebby from the severity of the necrotic process.

The first X-ray examination of the normal and the diseased thumb was made that afternoon, and the radiograms showed that the only part of the phalanx left was the base, and a bevel-shaped, pointed portion of the shaft. The patient's temperature after this remained normal, the wounds slowly granulated up, but the epithelium spread inwards under the excavated flaps, and a depressed, crucial scar, with hard, horny edges was formed, the deeper parts tending to fissure and crack in cold weather. The patient was unable to resume his practice till March 15th, having been off duty for five weeks.

The next X-ray examination was made on June 8th (three months after the removal of the necrosed bone), and it showed regeneration to a considerable extent of the expanded tip of the phalanx, the phalanx appearing shorter and thicker than in the normal thumb.

The patient now has a useful thumb, but the depressed tender scar, with hardened, corn-like edges and a tendency to crack in the deep parts, still gives him some discomfort. There is distinct shortening of the end of the thumb.

This case is typical of many one has seen where dead bone has been removed and the periosteum left. X-ray examination throughout a case of this type is of great value, and, if made use of in the early stages, will often save delay in the necessary operations. If the bone is attacked this is made evident at once by an undue transparency, and this would suggest the advisability of a deep incision exposing the bone. If, however, the bone remains normally dense, this procedure may be negatived. Increase of transparency in the bone would be an indication that the bone is becoming more involved. The converse, that is, the deposition of new mineral matter, is a sure sign of recovery.

I am indebted to Dr. Henry Sharman, of Hampstead, for the careful notes of this case.

Papers by Guy's Men.

J. S. Bookless: Case of Congenital Post-nuclear Opacity of the Lens.—Proc. Roy. Soc. Med., Ophth. Sect., June, 1914.

J. A. Glover: Rupture of Aneurysm of the Abdominal Aorta in a young woman.—Proc. Roy. Soc. Med., Clin. Sect., June, 1914.

Lieut. J. B. Hance: Retroversion of the Uterus and the "Sling Operation."—*Indian Medical Gazette*, July, 1914.

A. F. Hertz: Three members of one family suffering from Myotonia Hypertrophica—the Hypertrophic form of Thomsen's Disease.—Proc. Roy. Soc. Med., Clin. Sect., June, 1914.

W. Johnson: The Importance of Functional Activity in the Ætiology of Nervous Diseases.—*Quarterly Journal of Medicine*, July, 1914.

W. M. Mollison: Case of Carcinoma of Maxillary Antrum. Operation and Removal of Glands.—Proc. Roy. Soc. Med., Laryngol. Sect., June, 1914.

R. W. Murray: Geographical Distribution of Appendicitis.—*Lancet*, July 25th, 1914.

N. Mutch: The formation of B-Iminazolyethylamine in the Ileum of certain constipated subjects, with a note on the Urine in Constipation.—*Quarterly Journal of Medicine*, July, 1914.

H. M. Page: Intrapharyngeal administration of Warmed Ether Vapour by the Nasal route.—*Lancet*, July 18th, 1914.

W. S. Richardson; Pneumococcic Arthritis following Acute Pneumonia.—*British Medical Journal*, July 18th, 1914.

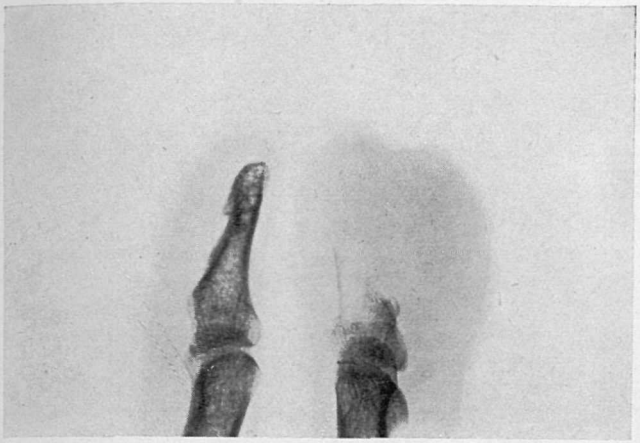
E. W. Sheaf and an other: Anoci-Association in the prevention of Shock and Post-operative Discomforts.—*British Medical Journal*, July 18th, 1914.

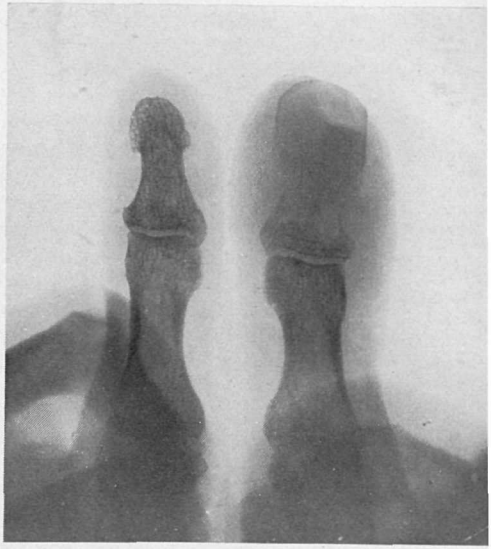
E. Bellingham Smith: Spina Bifida Occulta.—Proc. Roy. Soc. Med., Sect. Study of Dis. of Children, June, 1914.

Charters J. Symonds: Cancer of Rectum; Excision after application of Radium.—Proc. Roy. Soc. Med., Clin. Sect., June, 1914.

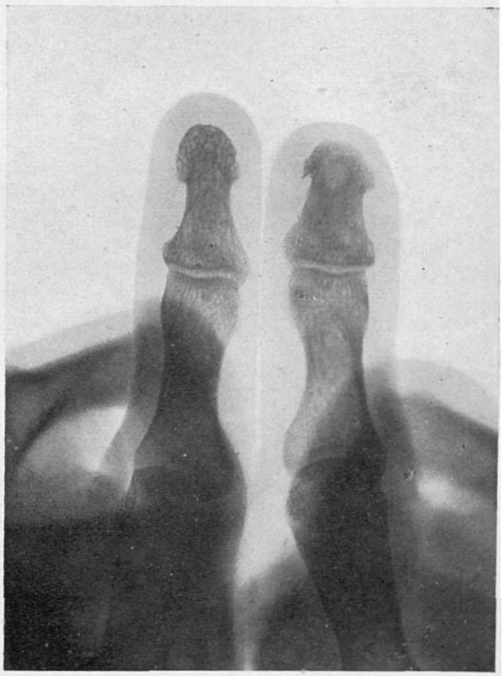
W. Hale White: Bolingbroke Lecture (Abstract of) on Prognosis.—*Lancet*, July 18th, 1914.

W. Hale White, J. H. Ryffel, E. P. Poulton, W. Johnson, and R. A. Chisolm: Study of a case of very pronounced Cheyne-Stokes Breathing.—*Quarterly Journal of Medicine*, July, 1914.





Condition on March 1st.



Condition on June 8th.

Skiagrams illustrating Mr. Shenton's Article (pages 287–288).

The Dental Society.

At the last Annual Meeting of the Dental Society, the following gentlemen were elected respectively:—President: F. B. Bull, L.D.S., Resident Dental Officer. Vice-Presidents: J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S. Eng.; E. C. Hughes, M.C., F.R.C.S.; E. B. Dowsett, M.R.C.S., L.R.C.P., L.D.S. Eng.; F. N. Doubleday, M.R.C.S., L.R.C.P., L.D.S. Eng.; J. B. Parfitt, M.R.C.S., L.R.C.P., L.D.S. Eng.; W. A. Hodgson, L.D.S. Eng. Hon. Secretary and Treasurer: W. J. Rousseau Viljoen. Committee: Messrs. D. G. Pearce, E. G. Browne, B. L. Laver, and E. Deverall. Dental Correspondent: L. H. Cross.

The attendance was one of the biggest on record; this was little to be wondered at for everybody was keen to give the popular and most able chairman a very hearty send off. The Society feels very greatly indebted to Mr. F. N. Doubleday, because there is no doubt that he took a very great interest in the welfare of the Society, and we can assure him that we very greatly appreciate everything he has done on behalf of that body. The Secretary's report was read and signed. It was also announced that Mr. D. Clewer won the prize for the best set of Casual Communications. After a vote of thanks had been passed to the resigning members, the meeting was adjourned.

W. J. ROUSSEAU VILJOEN,
Hon. Sec.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Lectures on Tuberculosis for Nurses. By Oliver Bruce. (H. K. Lewis.) Price 2s. 6d. net.

This book comprises the substance of a series of lectures delivered to the Queen Victoria Jubilee Nurses by the author and should prove of some value to the increasing number of nurses who are specialising in tuberculosis. It is, however, a matter of opinion whether a detailed account of the technique of opsonic index determination is of much importance to nurses, and we are surprised at the method advocated for drawing the necessary blood, namely, by plunging into the finger the pointed end of the capillary pipette! We have, moreover, never before heard of the "Tuberculosis Bill," but presume from the context that the National Health Insurance Act is implied. Throughout the book there is too much description of physical and other examinations which can, or should, only be made by a doctor. We wonder why a nurse should be taught the method of using a stethoscope or have described to her the antiformin method of sputum examination? In many places indeed it would appear that the author expected the nurse to settle the diagnose herself; as witness the following startling quotation: "Often, indeed, *you* will have to make a diagnosis on this (the temperature) alone." The italics are ours. Apart from these flaws, however, the book is very comprehensive and, if read judiciously, conveys much information in little space.

Spectrum Analysis applied to Biology and Medicine. By the late C. A. MacMunn, M.A., M.D. (Longmans, Green & Co.) Price 5s. net.

Dr. MacMunn of Wolverhampton was a busy general practitioner, a magistrate, and Colonel of Territorials, who devoted the leisure time allowed by these activities to investigations in spectroscopy and pathological chemistry. His scientific interests were by no means confined to clinical subjects, for he spent much time in the examination of the pigments of invertebrate animals and plants and in devising improvements in the spectrophotometer and fluoroscope.

The book in question was left unfinished at the author's death, and was prepared for the press by his widow and Prof. Gamble. One wishes that it could have contained a fuller account of MacMunn's own work, and fewer fragmentary quotations from other writers. The first chapter gives a very clear account of the physics of the spectrum; this portion might be read with advantage by candidates for examinations in physiology. The subsequent chapters deal with chlorophyll, hæmoglobin and its derivatives, the pigments of bile and urine, the pigments of invertebrates, and the technique of spectrophotometry. The least satisfactory section is the very brief and dogmatic chapter devoted to the subject of myohæmatin; a little more detail and a little less pugnacity would have provided better support for the author's views.

The book is well illustrated with numerous figures of spectra and apparatus. At the end is a valuable bibliography, which shows the wide range of the author's reading in physics, botany, and zoology. Of these publications, thirty-one bear the name of MacMunn, and give proof of his energy and pertinacity, which qualities are again evident in the portrait which serves as a frontispiece.

Cunningham's Manual of Practical Anatomy. Revised and edited by Arthur Robinson. Sixth edition. Vol. I., Superior Extremity; Inferior Extremity; Abdomen. (Henry Frowde, and Hodder & Stoughton.) Price 10s. 6d. net.

This manual is so well known to all students that it needs no introduction. On its first appearance it almost immediately leapt into first place among dissecting manuals and it continues to maintain its pre-eminence in spite of numerous recent attempts to supplant it. The energetic editor, however, has no intention of resting on his laurels, and as a result we have the first volume of a new edition following in less than two years

upon the last one. The whole text has been revised and several alterations made, but we are glad to see that the masterly description of the peritoneum which first appeared in the fifth edition has not been altered, whilst the illustrations in the same section have been considerably improved.

A notable and belated innovation is the addition of a number of radiograms of the bones and intestinal tract in an appendix at the end of the volume. It is high time that normal radiographic appearances were taught in the dissecting rooms and asked at the examination halls.

The Anatomist's Notebook. A Guide to the Dissection of the Human Body. By A. Melville Paterson, M.D., F.R.C.S. (Henry Frowde, and Hodder & Stoughton.)

This volume is not and does not profess to be a text-book of anatomy, or even a manual of dissecting. It is simply a well-arranged series of instructions for dissecting each part of the body, with lists of the structures to be found as each step is carried out. The relations and descriptions of the various structures are not included. The student is expected to refer to a systematic text-book for these, and to confirm them on his part. It is intended solely as a note-book for the student's guidance, and has numerous blank pages which he is encouraged to fill up with sketches from his part as he goes along. There are no illustrations in the proper sense of the word, but instead there are numerous surfae diagrams showing the points under which the morec important structures lie.

Both the diagrams and the instructions are all tha can be desired, but we do not believe that the book has any very large sphere of usefulness. To carry out Professor Paterson's scheme in its entirety would necessitate an exceptionally keen and intelligent group of students, and, in addition, the services of an experienced demonstrator for every five or six men. No doubt under these circumstances a descriptive dissecting manual could be dispensed with, but with the ordinary run of students, and the limited number of demonstrators ordinarily available, it would be, we imagine, impossible to carry out the scheme satisfactorily.

To leave the men to worry out their anatomy without help by their own industry and intelligence is to expect too much of them within so short a time of their leaving school; to provide them with minute help and attendance from demonstrators is an error in the other extreme, by not teaching them to work to some extent at least on their own initiative. After all, probably the most valuable result of the two years in the dissecting room is that the men come in as school boys, expecting to be spoon-fed, and leave as "students," willing and able to work intelligently without too much help. Professor Paterson's scheme would, one fears, tend to send them out, as they came in, school boys.

A Manual of Surgical Treatment. By Sir Watson Cheyne, C.B., F.R.C.S., F.R.S., and F. F. Burghard, M.S., F.R.C.S. New edition. Edited by T. P. Legg, M.S., F.R.C.S., and Arthur Edmunds, M.S., F.R.C.S. Vol. V. (Longmans, Green & Co.) Price 21s. net.

This volume completes the new edition of this well-known system of surgical treatment. The whole series has been thoroughly revised and overhauled, and now forms the best and most complete system of surgical treatment available. The authors and editors are to be heartily congratulated upon so worthily upholding the credit of British Surgery by their enterprise.

This last volume deals with the treatment of diseases of the pancreas, liver, spleen, neck, breast, thorax, and genito-urinary organs. That is to say, it is chiefly concerned with the great secreting glands of the body and their apparatus. It is in these regions particularly that the most recent advances of surgery have been made, and as a result this volume has been almost entirely re-written.

It is interesting to note that the authors have recognized that the day of one-man text-books is passing rapidly with the advent of the various specialists. They have wisely availed themselves of the help of Mr. Thomson Walker in the chapters on the examination of the urinary apparatus.

A detailed criticism is not possible in a short review, but one of the most striking features of the book is the general excellence of the descriptions of the more ordinary and simpler surgical procedures. The instructions are short and clear, not overloaded with unnecessary details, and are accompanied by a short discussion on tthe relative merits of the various methods in vogue. The same praise is due generally to the sections dealing with more serious conditions, but as a whole whilst the actual description of the technical details is all that can be desired, the discussion as to the relative merits of various methods of treatment is inadequate. This is especially the case in the chapters on simple prostatic hypertrophy and on renal tuberculosis. On the other hand, it is only fair to say that the review of the surgery of the thyroid gland is very excellent indeed.

The illustrations are rather crude, but are quite intelligible and no doubt sufficiently elaborate for all practical purposes. We are, perhaps, getting spoilt in this country in the matter of illustrations by the American text-books.

Altogether this volume worthily completes the new edition and shows no falling off in the general standard.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Pass List.

University of London.

M.S. EXAMINATION, July, 1914.

Branch I.—Surgery.

H. Gardiner. | V. Glendining.

A. H. Todd, B.Sc.

M.D. EXAMINATION, July, 1914.

Branch IV.—Midwifery and Diseases of Women.

R. Montgomery, B.S.

Branch V.—State Medicine.

H. L. Hopkins.

SECOND EXAMINATION FOR MEDICAL DEGREES.

Part II., July, 1914.

*†‡L. S. Debenham.	K. R. Traill.
G. W. Heckels.	M. B. M. Tweed.
†J. Joffé.	S. Vidôt.

*Distinguished in Anatomy. †Distinguished in Physiology. ‡Distinguished in Pharmacology.

University of Oxford.

The following Medical Degree have been conferred:—

D.M.: G. H. Hunt.

Examining Board in England by the Royal Colleges of Physicians of London and Surgeons of England.

At the Second Professional Examination in Anatomy and Physiology, held on July 2nd, 3rd, 6th, and 8th, the following candidates were approved:—

R. Aspinall-Stivala.	J. O. R. Montocchio.
N. A. H. Barlow.	I. Tewfit.
C. L. Curle.	K. R. Traill.
G. E. Kidman.	W. A. Turner.

K. F. McAlpin.

At the Quarterly Examination in Practical Pharmacy, held on July 9th, the following Candidate was approved:—

C. R. Cade.

Naval.

EXAMINATION FOR PROMOTION TO STAFF SURGEONS, R.N.

At the recent examinations, held at Greenwich and London, the following Surgeons qualified for promotion to the rank of Staff Surgeon.

Arthur T. Rivers. | K. H. Hole.

G. F. Symns.

Two of these officers—Surgeon Hole and Surgeon Symns—obtained First Class Certificates, thus becoming eligible for accelerated promotion to the extent of 12 months' seniority.

The Swimming Club.

INTER-HOSPITAL WATER POLO.

Final Cup-tie.

Guy's having easily beaten St. Bartholomew's in the semi-final by 6 goals to 1 on June 12th, they met London in the final tie on June 29th at the Aldgate Baths.

It was a very good game in which the Guy's team played better than ever before and beat the London men at all points of the game. In the end we won by four goals to two.

Guy's started swimming towards the shallow end. After a few minutes' play Ordish passed to York-Moore, who scored the first goal of the game. London replied by obtaining a goal through Hartgill. After some forward play York-Moore passed to Ralph, who shot our second goal. There was no further score till half-time Guy's then leading by 2—1.

On resuming, Ordish secured and swimming up the bath started an attack which resulted in York-Moore scoring once more. London then attacked strongly, and Hollings shot their second goal. After some scrambling play Ralph shot another goal.

When time was called Guy's were the winners by four goals to two. The team are to be greatly congratulated upon regaining the Cup after its absence from the smoking-room for two years. The energy of the captain, Mr. C. H. Laver, had much to do with this year's success. He aroused his men to such a pitch of enthusiasm that they practised hard three times a week in the Nurses' Bath for several weeks before the match.

Team:—A. G. Guinness, goal; F. G. Ordish, L. G. Whelpton, backs; C. H. Laver (Capt.), half-back; R. Ralph, J. York-Moore, A. L. Anthony, forwards.

Of the individual players, Guinness in goal was equal to our late goal keeper, Smythe, at his best and played a perfect game. Ralph in the forward line shot better, and got away with the ball better than ever before, and will be a very useful man in the team so long as he practises. Laver as half-back did the work of several men and made the forward line secure in attacking as strongly as they could. The backs played up better than usual, but there is room for improvement. They should pass the ball up to the forward line more quickly instead of trying to dribble so much.

INTER-HOSPITAL SWIMMING CUP.

This cup was retained by the London men, who beat our men in the team race by fifteen yards. The Guy's men individually swam faster than usual, but their opponents were altogether too speedy for them.

Cricket.

Review of the Season, 1914.

Before anyone had handled a bat, and any new men had come forward, L. H. Dixon, the Secretary, was confronted with the fact that several of last year's regular players had decided to take no part in the coming season. Moreover, considering the reasons given, we earnestly hope that they found the favour they desired from those whom they dared not leave even on a Saturday. The result of all this was that our first game had to be scratched, and further it become obvious that most of the 2nd XI. fixtures would have to be cancelled, and this is what actually took place.

Now on looking back at the end of the season, considering that the team won twelve matches out of twenty-four, including, mark you, the Inter-Hospital

Cup, a deep debt of gratitude is owed to those who so unselfishly gave up their time to play for the Hospital, and especially to those who in addition had the trouble of persuading men to play, and this task turned out to be a very unpleasant and disappointing one. On quiet consideration this lack of keenness is really a very serious matter; should it go on there can be no doubt but that the Hospital will lose the few remaining cups it now possesses, and the good name which past Guy's men have earned for us in being a "sporting" Hospital will become the heritage of one of our rivals.

Now turning exclusively to cricket matters we are glad to see that the 1st XI. at any rate fulfilled the greater part of their really good fixture list. We will not go into details, as already I fear we have used enough of your valuable space. But if you will permit a few words being said on the Cup Final we should like at the outset to mention the appreciation shown by Dr. Cameron and Mr. Fagge in being present at the match. With regard to what happened an extra tribute must be paid to D. M. Whitcombe and L. H. Dixon, the former, besides making a century, gave a really wonderful display behind the stumps, accounting for no less than six wickets in one innings, the latter for his usual brilliance with the bat and ball. In conclusion we wish to thank Mr. Fagge, our President, for the really great dinner and entertainment which he gave us last night at Hampton Court in honour of our victory.

INTER-HOSPITAL CUP (Final Tie).

GUY'S v. LONDON.

GUY'S (1st Innings).

C. Vincent Brown, c Fletcher, b Bray	0
L. H. Dixon, b Read	82
D. M. Whitcombe, b Pank	1
H. Sterne-Howitt, b Herman	15
A. C. Coxon, b Molesworth	8
B. F. Sampson, c Batchelor, b Herman	1
F. J. Biddle, b Bray	21
T. W. Sheldon, c & b Herman	9
R. Lindsay, not out	4
L. H. Gilbert, c & b Herman	1
H. M. Gray, c Read, b Herman	0
Extras	9
Total	151

GUY'S (2nd Innings).

L. H. Dixon, st Fletcher, b Herman	52
C. Vincent Brown, c Herman, b Bray	45
T. W. Sheldon, c Fletcher, b Herman	2
F. J. Biddle, b Pank	14
D. M. Whitcombe, c Pank, b Molesworth	110
B. F. Sampson, run out	1
H. Sterne-Howitt, b Read	16
A. C. Coxon, c Read, b Herman	29
R. Lindsay, b Read	10
H. M. Gray, not out	16
L. H. Gilbert, b Herman	2
Extras	16
Total	313

LONDON (1st Innings).

W. H. Sarra, st Whitcombe, b Biddle	7
E. W. Sharpe, c Whitcombe, b Dixon	6
P. E. Pank, c Whitcombe, b Biddle	2
A. E. Herman, c Sampson, b Dixon	3
G. W. Read, st Whitcombe, b Dixon	21
F. H. Bray, b Dixon	0
W. G. Fletcher, c Whitcombe, b Dixon	0
T. B. Batchelor, c Whitcombe, b Biddle	1
W. Schloss, c Lindsay, b Biddle	8
K. O. Brien, c Dixon, b Biddle	3
H. W. Molesworth, not out	0
Extras	5
Total	56

LONDON (2nd Innings).

E. W. Sharpe, b Dixon	3
W. H. Sarra, c & b Gray	39
P. E. Pank, c Sampson, b Dixon	15
A. E. Herman, c Sterne-Howitt, b Gray	31
D. G. Read, c Dixon, b Gray	2
F. H. Bray, b Biddle	42
T. B. Batchelor, c Whitcombe, b Gray	13
W. Schloss, not out	30
W. G. Fletcher, c & b Gray	0
K. O. Brien, b Biddle	14
H. W. Molesworth, c Coxon, b Biddle	0
Extras	14
Total	203

Marriages.

BROMLEY—LEE.—On the 2nd July, at Highfield Church, Earlsheaton, Lancelot Bromley, M.C., F.R.C.S., youngest son of Sir John and Lady Bromley, of Seaford, Sussex, to Dora Ridgway, youngest daughter of Mr. and Mrs. Arthur Lee, High Close, Earlsheaton, Yorkshire.

DEAN—FARMER.—At St. John's, Sharow, Ripon, on June 3rd, Laurence Thompson Dean, M.B., of Spilsby, Lincolnshire, to Gladys Margaret Farmer, daughter of Rev. James Farmer, Lucan House, Ripon.

KILLPACK—GIMSON.—On July 23rd, at Holy Trinity Church, Leicester, by the Rev. A. Lethbridge, Vicar of St. Peter's, Leicester, assisted by the Rev. F. Papprill, Vicar of the Parish, Charles Dones Killpack, M.B., B.S. Lond., of Haywards Heath, elder son of Mr. and Mrs. C. J. Killpack, of Leicester, to Annie, second daughter of Mr. and Mrs. Wm. Gimson, of Leicester.

MAXTED—HEWITT.—On Tuesday, July 14th, at Trinity Wesleyan Church, Macclesfield, by the Rev. Dr. Moulton, assisted by the Rev. S. R. Hewitt, brother of the bride, George Maxted, M.D., F.R.C.S., second son of J. D. Maxted, Esq., J.P., and Mrs. Maxted, of Littlebourne, Kent, to Dora, youngest daughter of T. H. Hewitt, Esq., F.R.G.S., and Mrs. Hewitt, of Fir Grove, Macclesfield.

WARNER—TAYLER.—On the 25th July, at Southwark Cathedral, by the Rev. W. C. Stainsby, Rector of Chigwell Row, Harold Percy Warner, M.B., B.S., of Rydal, Woodford Green, eldest son of the late Dr. Percy Warner, to Kathleen Rose, eldest daughter of J. P. Tayler, of Old Charlton, Kent.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 682.] AUGUST 15, 1914. [SIXPENCE.

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NOTICE.

ALL Medical Students, both those who are studying Preliminary Science Subjects, and Anatomy and Physiology, are urged to return to the Hospital, as soon as possible, when they will be instructed in Ambulance work generally, including antiseptic principles, bandaging, stretcher work, and first aid. It is hoped that it will be possible for each man to serve as Dresser in the Out-Patient Department and in the Wards. In the time that elapses before the commencement of the Hospital Session on October 1st, it is hoped to be able to provide for a Course which will render all men volunteering for service efficient Dressers in the event of their being called upon for service by the War Office at the base Hospitals or elsewhere.

Passim.

ONCE again the shadow of war has fallen upon Europe. The domestic trials of our country are forgotten, and the nation stands as one man to defend itself and assist our allies in one of the most serious struggles which the world has ever seen. Only last year, at The International Congress, when doctors of all nations, bound by a common tie for the alleviation of human suffering, met in London. Sir Thomas Barlow spoke of the influence of the Medical Profession of the world in the preservation of International peace.

The events of to-day show how vain are such hopes in the present state of civilization: will the world ever reach such a Utopian ideal? We venture to think not, and, if such a condition should mark the decline of patriotism, of individual effort and self-sacrifice, we hope not. The absence of danger from invasion inevitably destroys the spirit of a nation and brings in its train domestic troubles which sap the vitality of its people. The scientific and social progress of the world has been written in blood. The struggle for existence and the punishment of the tyrant are physiologically necessary. But the punishment must be complete so as to ensure a long period of peace, during which to take advantage of the lessons learned in the struggle.

THE readiness with which men have come forward in all parts of the Empire, sends a thrill of pride through us all. The blood courses more quickly in our bodies, old men feel young again, and young men, whose exuberant spirits must be carefully guarded by those with some former experience of trials such as those which have now befallen us, hurry forward to defend our honour.

LET us now consider a narrower outlook, namely the effect of recent events on our Hospital life and work. The news of the war fell like a bomb and paralysed us for a moment. We stood in little groups, discussed the situation, and saw but one duty! Men who were bound by oath to serve the country have honourably

redeemed their pledge, and others, not so bound, have entered the various medical services. As a result of this the number of workers in the Hospital, both qualified and unqualified, has been seriously reduced. Naturally enough, in such a state of affairs, the patients under our care run a risk of being neglected. Thus, another duty stands equally clear to those of us who remain. We must avoid panic, and not let the excitement of the moment cause us to neglect our duties to the alma mater which has given us our professional training, and so placed us at an advantage over thousands of unskilled workers in this time of trial. Let us remember that there is noble work to do here. Heaven knows it is hard enough to stay! but we must restrain ourselves, bearing in mind that "They also serve who only stand and wait." It is the duty of every remaining man holding an appointment to abide loyally by the decisions made by the Governors and Staff of the Hospital.

Everyone must realize what a weight of responsibility now rests on the Superintendent and Dean, and by loyally supporting them, we shall perform a service to the nation.

We reprint elsewhere in this issue letters addressed by the Superintendent to the War Office, and, if the offers therein expressed are accepted, the Hospital will have ample opportunity of doing its part in this emergency.

We also print a list of revised appointments made by the Dean.

Classes in Elementary Surgery are to be given by the Registrars to junior men to enable them to perform the duties of Surgical Dressers in the Out-Patient Department.

The Clubs' Union has also offered the use of the Students' Club to Special Constables (see letter in this issue) posted in this district. By these arrangements the Hospital is able to do its duty to the sick civil population, and at the same time help the State by providing accommodation for soldiers and sailors, and by keeping up a supply of future medical men.

A dental unit is proceeding shortly to Wimereux (Pas de Calais) to assist Mr. Newland-Pedley, Consulting Dental Surgeon to the Hospital, in the formation of a private clinic for the dental treatment of the French and English troops, including the treatment of fractures of the jaws. Two other units are also in the process of formation.

We regret that, after making excellent progress, Mr. L. A. Dunn had a slight relapse this week. We hope that he will soon recover, and look forward to seeing him in the Colonnade again, arm-in-arm with a colleague or member of his firm. The Thursday afternoon round is greatly missed by the harassed examination candidate, anxious to know some of the subtleties of the examiners' craft.

On August 1st, the new members of the Resident Staff took up their duties, and elected Mr. Clifford and Mr. Evans to act as President and Vice-President for the next three months. We are glad to see that Mr. Seabrooke and Mr. Ryle, their predecessors, have not left the Hospital for good. Mr. Seabrooke is returning in September, as Junior Charity, and Mr. Ryle, as Medical Registrar, in October.

Congratulations to Dr. Frederick Taylor on his election as President of the Royal Society of Medicine. Dr. Taylor is still a familar figure in the Hospital, and has done an enormous amount of work as Physician, Author, and Examiner. He is a member of the Senate of London University, and was formerly President of the Medical Section of the Royal Society of Medicine. This latest honour is a fitting recognition of his varied services to the Profession.

Mr. Sampson Handley has again been appointed Hunterian Professor to the Royal College of Surgeons. A member of the younger school of Guy's men, he has obtained distinction chiefly by his researches on cancer at the Middlesex Hospital. He has previously given Hunterian Lectures on The Dissemination of Mammary Carcinoma, Melanotic Sarcoma, Lymphangioplasty and the Surgery of the Lymphatic System.

Copies of Letters addressed to the War Office by the Superintendent.

Guy's Hospital,
August 8th, 1914.

Dear Sir,

I find that in addition to our Wards, in which we have just over 600 beds, there is room in the "Park," within the Hospital, for about 150 additional beds in wooden huts.

I am aware, of course, that it is the intention of your Department to open four large General Hospitals in London—about 2,000 beds—and you have, no doubt, the offer of numerous private houses for the accommodation of sick and wounded soldiers. It is quite likely, therefore, that you are of opinion that at the present time you have ample accommodation, but I should like you to know that the Governors and Staff of Guy's are desirous of helping in this National Emergency to the utmost of their power, and, if you think it likely that you may require this extension of Hospital Beds, to be worked as a part of Guy's Hospital by our own Medical and Surgical Staff, House-Officers, Students, Sisters, and Nurses, perhaps you will give me an opportunity of seeing a Representative of your Department without delay.

I am, dear Sir,
Yours truly,
Superintendent.

The Director General, A.M.S.

Guy's Hospital,
August 8th, 1914.

Dear Sir,

Our Dental School are very anxious to help the War Office in this national crisis, and it has occurred to our Dental Staff that the best way to do so would be to undertake the dental treatment of men offering themselves as recruits who have been rejected on the ground of defective teeth.

As some indication of the amount that can be done here in the matter of dental treatment, I may say that we are prepared to provide fifty dental chairs, which will be available for patients for six hours a day, and there is also a large department for extractions.

After October 1st, when our Dental Session commences, the work would have to be somewhat limited, but could be continued on a lessened scale.

As regards finances, the Dental School would be prepared to charge the War Office only the actual cost price of the materials used, which would naturally be of the cheapest description compatible with effective treatment.

I am, dear Sir,
Yours truly,
Superintendent.

P.S.—We are prepared to start as soon as ever we hear from you.

The Director General, A.M.S.

Guy's Hospital,
August 8th, 1914.

Dear Sir,

It has occurred to our Governors and Staff that Guy's may be of some service to you if we were to take in to our Surgical Wards the men applying for recruits who have been rejected for Varicocele, so that they could be operated upon speedily and in time perhaps for future utilisation.

If this suggestion appears to you to be of value, perhaps you will let Recruiting Surgeons know that they may refer cases to our Surgery here with a card directed to our Resident Surgical Officer.

I am, dear Sir,
Yours truly,
Superintendent.

The Director General, A.M.S.

University of London.

August, 1914.

DEAR SIR,

I have been asked by the Vice-Chancellor of the University to ascertain which of our students who are not members of the O.T.C. (the services of cadets being required elsewhere) would be willing to act as Special Constables in the event of a force being formed to insure the quiet and safety of London. Those who enrolled would be asked to serve in plain clothes for four hours a day and to give their services without pay.

If you are willing to assist in the way mentioned kindly fill up the form below and forward it to me as soon as possible.

Yours faithfully,

Name in full.....
Address (permanent) .....
,, (Temporary) .....
Period of Temporary Address .....
Age.....Height.....Chest Measurement.....

I am willing to serve in plain clothes as a Special Constable for four hours a day without pay in the event of my services being required in London.

Signature.....

Date.....1914.

Ralph Wingent Memorial Fund.

EIGHTH LIST OF SUBSCRIPTIONS.

	£	s.	d.
Stanley Cock, 4, Fitzroy Street, W.	0	10	6
Gordon Covell, I.M.S., *en route* for India by s.s. *Dongola*	0	10	0
Leslie Doudney, West African Medical Service	0	10	6
Henry Millson, Great Maze Pond, S.E. ...	1	1	0
The "Guy's Hospital Gazette"	4	4	0
	6	16	0
Previously acknowledged (July 1st, 1914) ...	35	1	6
Total	£41	17	6

H. C. MANN,
P. S. PRICE,
Hon. Secs.

August 10th, 1914.

BOOKS, ETC., RECEIVED.—Nursing Times, The Hospital, St. Bartholomew's Hospital Journal, and New York State Journal of Medicine.

The Late Results of Fracture of the Base of the Skull.

BY A. J. EAGLETON, M.B., B.S. (LOND.).

IN dealing with cases of fractured base, which take some time to recover sufficiently to permit of the patient's discharge from hospital, it is difficult to distinguish between a complication and a late result. But it is convenient to regard as a complication any untoward symptom which prolongs the patient's stay in the ward, and to include under the heading of late results the state of the patient on and after his discharge. With regard to the former of these it is easy enough to obtain facts and figures, but to get in touch with patients who have left a hospital it may be five years or more is a matter of great difficulty. William Bullard* traced the after-history of 19 cases of fractured base; of these three presented serious symptoms when seen over a year later:—

1. Male, 48 years of age. Hard drinker before the accident; but afterwards small amounts produced "awful effects." He is described as being "crazy since the injury."

2. Female adult, probably alcoholic. Became melancholic.

3. Boy, aged 12. Hæmorrhage right ear. Eighteen months later slightly deaf, headache and dizziness. Cannot learn at school.

The chief symptoms complained of in the other cases were headache, vertigo, and deafness. These three usually co-existed. He also lays stress on the increased susceptibility to alcohol, as mentioned in Case 1. Tinnitus, he remarks, is sometimes present, but is not complained of in connection with deafness.

Crisp English† more recently has followed out the late results in 100 cases of fractures of the skull. Though fractures of all kinds were included, his results may, *mutatis mutandis*, be applied to basal fractures. He especially investigated the effect on the wage-earning capacity of the patients. Of 86 cases in which this was ascertained, in 52 there was no change of employment: 13 were doing lighter work, 7 very little indeed; 8 had to change their employment, while 6 were totally disabled. The chief disabilities beset with are giddiness, especially affecting bricklayers, sailors, etc., difficulty in remembering names of streets, inability to stand the hot weather, and chronic headache of every variety.

With regard to giddiness in the cases personally investigated, this has not appeared a prominent late symptom. It was not spontaneously complained of in any case, and only a very vague history was sug-

*Boston Medical and Surgical Journal, 1897.

†T. Crisp English, *Lancet*, 1904.

gested in one instance—a little boy with an anxious mother. English, however, gives the figure as high as 20 per cent. of all cranial fractures, and states that it is best marked in the early morning and apparently has no connection with lesions of the vestibular nerve.

The commonest form of chronic headache is described as fixed and usually intense, and sometimes associated with local tenderness. It is due to sclerosis of the bone healing at the site of fracture. This is not found in cases of fractured base, as a repaired basal fracture is a rarity. There is a specimen in the Guy's Hospital Museum.* This was exhibited before the Pathological Society in 1873.† In it the petrous portion of the temporal bone was mainly involved. Two other specimens are recorded as shown before this Society, one in which the orbital plate of the frontal, and another where a fissure in the posterior fossa showed signs of repair.

Cases have also been reported from America; but, as a rule, owing presumably to its lack of cancellous tissue and relatively poor blood-supply, the base of the skull shows no power of regeneration. This is very fortunate, as the liability of nerves, etc., to injury would be vastly increased by the reparative process of callus-formation.

The mental changes are not much marked in the class of patient treated at general hospitals, but with business or intellectual subjects they may be very serious. The arithmetical faculty is much affected; amnesia may be an early symptom and improve with time or may be first noticed some months after the injury. It is often limited to a loss of memory for streets or names of persons or books.

The nature of the accident and the illness are often forgotten, and frequently a period previous to the accident become erased from the mind. This was well shown in one of our cases who kept wandering back and talking to his wife who had been dead some while. There is every stage of neurasthenia from a mere nervousness, loss of nerve, an inability to cross a street, somnambulism, etc., to the so-called traumatic neurasthenia. This has been given various names, such as railway spine, spinal concussion, traumatic neurosis, and accident aboulia.

The symptoms are all real, but subjective, and include weakness, headache, noises in the head, photophobia, pains in the back, and a perverse delight in revealing the horrors of the accident. It is found in all severe injuries; and it may delay recovery for a long time.

The prognosis is good, 70 per cent. recovering entirely, while the remainder usually show considerable improvement. Of eleven cases recently treated at the Charing Cross Hospital, all recovered except one.

*No. 3816.

†C. Hilton Fagge, M.D., Trans. Path. Soc., vol. 24, 1873.

which terminated in acute mania. There is often a change in character. The friends remark that "he is not quite the same now" since the accident. There may be depression or irritation, rarely leading to insanity; the patient ages very rapidly. These symptoms are better marked in the intellectual classes. It will be seen later that among our cases the mental defects if present at all were usually of a grave character.

Traumatic epilepsy is a subject on which a vast amount of literature has accumulated. English reports six cases where it apparently followed a fractured base. The difficulty is to know whether the accident took place as a result of a fit or whether the epileptic manifestations dated from the accident. In one case in our series an epileptic seizure gave rise to a fractured base, after which although the fits were usually separated by intervals of at least a month, the patient had one fit after another, passing into the status epilepticus.

Traumatic insanity is a very vexed question. English gives 11 cases, all of which were found in alcoholic subjects. Schlager, of Vienna, says that 10 per cent. of all cases of insanity are traumatic, while Clouston says only 1·3 per cent.

At a recent meeting of the British Medical Association* Dr. Mott expressed very strong views against the idea of traumatic being solely responsible for any insanity. Of 7,640 cases admitted to the Bexley Heath Asylum only 36 had any traumatic origin, and in these it was only contributory. Other authorities concurred in this opinion, but it was generally allowed that trauma might light up a gumma or other latent disease. This might account for the fact that general paralysis of the insane is sometimes apparently traumatic in origin. "A head injury of a more or less serious character is not uncommonly met with in the history, and no doubt it must be regarded as an exciting cause."† Crichton Browne says that trauma was the exciting factor in 3 of 42 cases. Other writers give the proportion as high as 11 out of 60, or even 47 out of 104 cases.

The Argyll-Robertson pupil is sometimes absent when all the other signs point to general paralysis. Clouston, who seems opposed to the idea of trauma as a cause of insanity, says he has only seen one case of real progressive general paralysis following an injury.

With regard to the increased susceptibility to alcohol, English says, "A glass of wine or beer may turn these patients from apparently sane beings into irresponsible criminals."

There are other rarer mental changes which need not be entered into.

English sums up his observations on the cerebral symptoms, which occur as the late results by saying, "All but the slightest of the contusions and lacerations

*Vide *Lancet*, July, 1911.

†Psychological Medicine—Craig.

of the brain are followed by permanent changes." Usually when once a patient has apparently made a complete recovery he will remain free from any further effects; if head symptoms develop later they are due to other causes.

We have considered the lesions of nerves liable to occur; some of these are first noticed as a late result. Thus, cases are recorded where the sense of smell was lost over a year after the accident. Blindness in some cases occurs long after the injury—in two of English's cases, eight and fourteen months afterwards. The condition known as accommodative asthenopia is met with occasionally; there is a feeling of weakness after very slight movements of accommodation, and on examining the object closely the vision becomes blurred. Facial paralysis may persist, though in most cases it is transient. Deafness, again, is frequently met with; English says in 12 per cent. of all skull fractures. It certainly is much the commonest late symptom in cases of fractured base, and seems more liable to follow in cases where the primary aural hæmorrhage is succeeded by an obstinate serous discharge, or, a rarer complication, otitis media.

One other symptom, which is certainly of cerebral origin, may be mentioned, namely, glycosuria. It may be transitory, occurring soon after the accident or it may not appear for some time and then persist. English records the remarkable case of an officer in Egypt who fractured his basis cranii. He was unconscious for a long time and six weeks later developed glycosuria. He became comatose, but eventually recovered.

Although the so-called diabetic or sugar centre has been located in the medulla, it has been shown that any severe cerebral injury may produce glycosuria. It is very likely a common complication, but as, when the cerebral symptoms are most marked, the urine is rarely tested for sugar, its presence may be overlooked. We will now finish our observations on late results with a consideration of those of our cases that have been traced and seen at varying times since their accident.

Of the cases in our series 72 died, 61 recovered. Efforts have been made to trace all the survivors, but only 20 have been found; writing to the addresses given in the reports was found to be useless. But even when the addresses were visited only a third were followed out; in 13 further cases, that were not seen recently, the condition on discharge was sufficiently definite to admit of their inclusion among the late results. These 33 cases will be considered in three groups, according to the late symptoms observed. Cases with :—

(a) Grave mental symptoms.
(b) Slight mental and other symptoms.
(c) No permanent disability.

(a) Nine cases in all, 4 of them traced, 5 not seen since their discharge.

1. Woman, 28. Accident 11 years ago. "Irritability" six days, temperature reaching 102° F. On discharge mentally deficient; removed to an infirmary where she remained twelve months. For two years after that she seemed "peculiar" and halted in her speech, but was able to fulfil her household duties. She then died, but the cause of death is uncertain.

2. Man, 48. Three days' "irritation." Retention of urine, obstinate discharge from ear. He is now in an infirmary, is unable to work, and is dull mentally; seven years since the accident.

3. Man, 80. Very slight accident three years ago; never recovered his former mentality. He is since dead.

4. Man, 41. Accident five years ago. "Irritation" eight days. Three weeks in the strong room and unmanageable afterwards. Removed to lunatic asylum three months later; he is still maniacal.

5. Man, 45. "Irritation" prolonged for six days; still mentally defective on discharge. He has not been traced.

6. Woman, 40. Irritation on and off for 20 days; delirium. Seen on discharge by Dr. Craig who diagnosed loss of memory, due primarily to alcohol, accentuated by the accident.

7. Man, 50. Irritation four days; delirium; memory bad; not traced.

8. Woman, 66. No remarkable cerebral symptoms. On discharge melancholic. No trace.

9. Man, 46. Maniacal; only in the hospital three weeks; mentally dull. Not traced.

Of these cases with marked cerebral symptoms seven showed a prolonged period of irritation, in four cases associated with mania. In the one case in which a definite alcoholic history is given the signs of laceration persisted for twenty days. The other two cases presented no remarkable symptoms. The patients were aged 66 and 80, and this seems to have been the main determining factor. Incontinence of fæces, retention or incontinence of urine are very grave prognostic signs.

(b) The less serious symptoms complained of were deafness, otorrhœa, headache, and tinnitus.

An increased susceptibility to alcohol was only noticed in one case. The patient's wife was seen ten years after the accident. He was doing hard work and seemed quite well, but he was liable to get very cross-tempered and drunk very easily. On looking up the case it was found he had four days' irritation, with possibly delirium tremens. Deafness is far the commonest late result, being present in seven cases. It was associated with otorrhœa in two, but there was no case of a discharge from the ear persisting for more than twelve months. Headaches are not common, and when found are slight. Tinnitus was the only symptom in two cases. Dizziness is not common, though the patients included a painter, sailor, carpenter, van boys, and warehousemen.

None of the cases grouped among these with slighter symptoms were incapacitated from work. Headaches and tinnitus followed in cases with no especially suggestive symptoms. Deafness followed hæmorrhage from the ears and otorrhœa. It is permanent, and was observed 3, 4, 6, and 8 years after the accident. A facial paralysis persistent on discharge is noted in the case of one patient. None of the cases traced had any affection of the facial nerve at the time when they were seen, but in one case it had been treated for six weeks in the electrical department and had since disappeared.

(c) Thirteen cases in which there were no prominent ill effects :—

1. Girl, 15. Slight accident. No irritability or subnormal temperature; short stay in the ward; well on discharge. Not traced.

2. Boy, 7. All three fossæ involved, but no marked cerebral symptoms. Irritation just under two days. Only 3½ weeks in; well on discharge. Not traced.

3. Boy, 17. No "irritation" at all. Hæmorrhage from ears. Very slight accident; well on discharge. Not traced.

4. Woman, 25. Temperature almost normal all the time. Hæmorrhage left ear. Alcoholic. Not traced.

5. Boy, 10. Anterior fossa. Very slight "irritation"; no subnormality; quite well; clever at school; now at work. Mother seen eight years later.

6. Boy, 4. Anterior fossa. No "irritation"; slight subnormality. Seen seven years later. Employed as an errand boy; seems quite well. Not good at school, but none of the family are.

7. Girl, 4½. Slight accident. Anterior fossa. No irritation. No apparent ill effects.

8. Man, 40. Carpenter; fall off bicycle; very slight violence. Still does same work and is quite well. Seen three years later.

9. Man, 23. Quite well. No complaint; same work. Seen five years after accident. Nothing remarkable; hæmorrhage nose.

10. Boy, 5. Slight accident. Seen five years later; vague history of dizziness. Employed as errand boy.

11. Man, 31. Sailor. Family seen four years later; quite well. Still in navy.

12. Man, 21. All three fossæ, but very slight lacerative signs. Clerk, alive and well; good business man. Housekeeper seen four years later.

13. Boy, 14. Slight accident. In four weeks anterior fossa. Lacerative symptoms mild. Not traced.

The first thing that strikes one is the age of this group of patients, eight of them being under 20. The second fact to be noticed is the good ultimate prognosis in fractures of the anterior fossa; and the third third is the reverse of what we noticed in the first group, namely, the absence of any but the slightest degree of cerebral laceration. It is, of course, difficult to estimate mental disturbances or changes of character in the children, and we cannot say what they would have been if they had not had the accident. It is remarkable, however, that in all cases where the boy's work at school was inquired into they were never backward.

These results go more than ever to strengthen the view that it is the laceration that matters in the after results. If they recover from compression, they recover completely. Of the patients seen, all were reported on at least two years after the accident. In many of the cases it was remarked by the friends or relations that they did not seem to get over it for about a year.

Associated with this we have the fact that most of the cases on discharge have a subnormal temperature, in spite of good food and tonics.

The prognosis of the various complications and the significance in this respect of the main symptoms have already been dealt with. Here we shall review the subject generally, only dealing with the signs most frequently observed.

From the point of view of prognosis, cases of fractured base may be divided, after Jacobson's plan, into three groups : Those hopeless from the first; those who will almost certainly recover; and the doubtful cases. We have seen that over half the fatal cases die within twelve hours of the accident; these are the hopeless cases which either come up in a state of profound shock or presenting all the signs of cerebral compression. Whether the patient will recover from the shock depends on several factors :—

1. Severity of the injury to the head and other parts, extensive cerebral laceration, or an escape of brain substance are very bad signs.

2. The depth of unconsciousness, state of the pulse, respiration, etc.

3. The fossa involved, a fracture of the posterior being associated with the gravest outlook owing to the presence in it of the vital centres.

4. The general condition of the patient, his age, the state of his arteries, and heart.

Yet with all these points in his favour a patient may succumb, and the most apparently hopeless cases survive. True, indeed, are the words of Hippocrates, *Nullum capitis vulnus contemnendum,* aptly paraphrased by Liston, no injury of the head is too slight to be despised or too grave to be despaired of. If the patient survive the first twelve or eighteen hours he will generally live at least two and a half days. The condition of irritation, which lasts two days, should then have passed off, if the patient is to make a complete recovery.

We have seen how much graver even in the surviving cases the prolongation of this period renders the prognosis. The height of the pyrexia at this stage is important; in no case in our series in which the

temperature reached 103° F. did the patient survive. It is at this time, too, that cerebral compression and meningitis are likely to supervene; compression may, of course, be the first condition noticed, and in such cases the prognosis is necessarily grave.

If the patient survive the second crisis, compression does not occur, not once in all our cases. Any subsequent rise of temperature may be due to laceration, and more rarely meningitis and cerebral abscess.

We have seen how this last condition may remain absolutely latent for weeks, months, or even years. With the exception of these complications, when once the temperature has fallen to normal there need be no other anxiety. Other sequelæ usually persist as permanent results, mental impairment, chronic otorrhœa, and deafness, liability to headache, etc. English gives as the main factors that effect the late results :—

1. Natural temperament, neurotic tendencies, etc.
2. Antecedent state of health, especially influenza.
3. Severity of the injury.
4. Efficacy of treatment.
5. Age, alcohol, social status, etc.

He regards the outlook as bad at the extremes of life; while this, if true of the old subjects, our results indicate a good prognosis for the young.

With regard to delirium or acute mania, this is not, *per se,* a grave sign, but as it implies either an alcoholic tendency or severe cerebral laceration, the prognosis must be guarded. The patients occasionally die during the maniacal stage, but usually recover, except for mental impairment. Rarely the acute mania persists, as in one of our cases, who is still in the Claybury Asylum, although the accident took place three years ago.

The influence of hæmorrhages on prognosis has already been dealt with. The discharge of cerebrospinal fluid is apparently of no significances, good or bad. It will be realised that, until the irritative stage is passed, the prognosis of fractured base cannot be given even for a day ahead. It is in many cases only a matter of hours for a complete change to come over the picture; the patient from being slightly irritable is tossing in wild delirium, or over the scene may drop a curtain of impenetrable stupor. The importance of the temperature has been fully considered.

The prognosis of the late results and complications have been dealt with. The conclusions we may draw are distinctly hopeful; cerebral compression once relieved may produce no permanent effect; severe cerebral laceration, fortunately much rarer, is always associated with grave after results. Laceration can never be remedied, whereas improvement in the treatment of compression is daily taking place. There is thus every hope that in the future we shall only look upon cases with severe laceration as hopeless from the first.

The International Dental Congress.

THE Sixth International Dental Congress, for the success of which such great efforts have been put forward for the past two years, met with hopeless failure during last week. The news of war came too late to abandon the Congress before its start, and too early to allow anything of importance to be done. A week either way would have been sufficient. As it was the Congress started with a dinner given at the Hotel Cecil by the Officers of the Congress to the Honorary Presidents, of whom only three or four attended. Not one of the original responders to the Toast of the Visitors was present, and it was replied to by one American and one French-Canadian, the latter of whom had fled precipitately from Paris with his family. The clothes that he stood in were borrowed ones.

The informal reception which followed was well attended, chiefly by the English contingent with a sprinkling of Americans and a few foreigners—mostly Russian.

The opening meeting took place the following day, Tuesday, at the Central Hall, Westminster, and was fairly well attended. Of the four big addresses to be delivered in the afternoon, only two were given.

The reception at the Guildhall in the evening by the Lord Mayor and Lady Mayoress was held, but this was the last of the social functions, the Government Dinner on the Wednesday, the Congress Banquet on the Thursday, the Hospital Garden Party, and the British Dental Association's Reception at the Natural History Museum on the Friday, all being abandoned. An attempt was made to hold the section meetings, but in nearly every case with failure—one section not meeting at all. The Museum of the Congress, which had taken weeks to assemble, was hurriedly dismantled on the Thursday morning—the Congress was supposed to finish on the Saturday—on the receipt of the news that the buildings at South Kensington were required for the use of troops.

Thus ended what had promised to be by far the most successful Dental Congress ever held, and we can only offer our sincere sympathy to all those officers, members, and visitors, and institutions whose plans were so rudely upset, and especially to those readers of reports and papers whose reports or papers were not read, or were only listened to by an audience of one or two. One reader of a report who came from Philadelphia, and had brought two patients with him for the illustration of his report, found no one in the theatre to whom to read the report or show the patients. He suggested to the assembled officers that they should journey to the Museum where he would explain the exhibit illustrating the report. On his arrival there he found the exhibit being hurriedly packed.

Syphilitic Affections of the Upper Air Passages.

A Post Graduate Lecture by Mr. W. M. Mollison.

Gentlemen,—I propose to-day to consider syphilitic manifestations and their results in the upper air passages, and I shall illustrate the various points as far as possible by cases seen in the Ear and Throat Department at Guy's Hospital this year.

The arbitrary conventional division of the course of syphilis into three stages marked by certain periods of time is found to break down when applied to the upper air passages; for instance, we find lesions, which pathologically are gummata, appearing during the first twelve months after infection; it is, perhaps, better therefore to consider (*a*) the primary infection—chancre, (*b*) constitutional syphilis which may give rise to *early* lesions—erythemata, papules, ulcers, or *later* lesions—gummata or infiltrations. In the case of congenital syphilis the constitutional lesions are similar to those of the acquired disease.

Primary infection may occur in any part of the nose, mouth, pharynx, nasopharynx, or larynx, but is rare; on the other hand, the lips are the most frequent site of extra-genital chancres. Chancres do occur on the tonsils and tongue through infection by spoons, forks and pipes; they have been seen in the nasopharynx, almost invariably due to infection by the careless use of the Eustachian catheter infected from another patient; in the nose they are occasionally seen on the septum or inferior turbinal.

When a chancre does occur in any of the positions mentioned, it is characterised by the intensity of the local inflammation, frequent ulceration, and by a marked enlargement of the lymphatic glands draining the affected area.

Secondary and tertiary manifestations are not so easily divided off from one another in the nose and throat as in other parts of the body; particularly is this so in the larynx where lesions which pathologically are to be regarded as secondary come on years after the primary infection, and conversely lesions which would be elsewhere regarded as tertiary, occur in the larynx a few months after infection.

Constitutional syphilis in the nose shows itself early as an erythema or papule, which may form an ulcer, and later as a gumma or an infiltration; both forms tend to ulceration.

Secondary lesions are not seen so often as they occur because the nasal symptoms are often slight and overshadowed by other secondary lesions for which the patients seek advice. Secondary lesions occur either in the form of an erythematous rhinitis or a papular rhinitis; both forms may lead to ulceration. A secondary syphilitic rhinitis gives rise to symptoms as of a catarrhal rhinitis, except that it is usually unilateral and very persistent, at the beginning too this discharge is less than with catarrh.

In congenital syphilis "snuffles" is a secondary rhinitis, though it may also be the first stage of a tertiary atrophic rhinitis.

The later constitutional lesions are in the form of gummata as a rule, they may occur in any part, most often on the septum or floor, but sometimes in the outer wall. A gumma may begin in the mucous membrane and infiltrate the underlying cartilage or bone, or it may originate deeply and involve the overlying mucous membrane. In any case it is apt to lead to caries or the formation of connective tissue; this latter gives rise to adhesions between the septum and outer wall.

Here are five cases of syphilis of the nose illustrating the various points; the first is a man of 49, who was seen in November, 1913; he then had had some headache for five weeks, some pain in the left side of the nose for four weeks; there was a shallow ulcer on the left side of the septum; this ulcer was more or less circular in outline, it lay partly over the cartilaginous and partly over the bony septum, and its edges were heaped up above the general level of the septal mucous membrane. To-day the site of the ulcer is still visible, but under treatment with neosalvarsan and mercury and iodide it is practically healed. The patient had a primary chancre twenty-seven years ago. This case was probably an example of syphilitic hypertrophy of the mucous membrane—a so-called "syphilitic tumour." This form of tertiary syphilis occurs on the septum or floor of the nose, and if untreated may lead to necrosis of cartilage or bone. Usually the patients complain of marked nasal obstruction and get considerable crust formation.

The second case is that of a man of 32 with complete destruction of the cartilaginous and bony septum of the nose with only very little external deformity, a slight falling in at the junction of the cartilage with the nasal bones; on looking into the nose it is seen that there is considerable atrophy of the outer walls, and owing to the complete disappearance of the septum the posterior nasopharyngeal wall is clearly seen. He also has perforation of the soft palate near its junction with the hard. Seen first in December, 1913, he stated that small pieces of bone had been coming away

from the nose for three or four years, but that his throat had been sore only two months. Fluids pass from the mouth into the nose. He had been referred from the Skin Department, and had a very severe pustular iodide rash: he was admitted and given an intravenous injection of salvarsan, and was much benefited thereby. This case is a good example of gummatous ulceration of the septum (and soft palate) and shows how very extensive the destruction of the bone may be; further, it demonstrates very well that in spite of total loss of the septum the external deformity of the nose may be almost nil; the explanation of this well recognised fact is not clear.

The third case is that of a man of 35 with gummatous destruction of the right ethmoid. He complained of a right-sided foul nasal discharge with crust formation and occasional obstruction. He dated it from a slight blow on the bridge of the nose six weeks previously, though he seemed to have had nasal symptoms for four years. He had right-sided frontal headache, some pain in the right eye, and tenderness over the right frontal region, and on pressing the bridge of the nose. He stated that a small piece of bone had come away from the nose. On examination it is noticed that there is much crust formation and pus in the right side of the nose, and the pus seems to arise in the region of the middle turbinal; there is some atrophy of the right inferior turbinal. The Wassermann reaction was strongly positive, and after using a nasal douche and taking some potassium iodide the headaches disappeared and the tenderness, too. This man also had an intravenous injection of salvarsan.

This case is one of gummatous disease of the right ethmoid, and the symptoms of the patient were typical of the disease. The history of the piece of bone coming away, in a case of a foul-smelling discharge, should make one very suspicious of a gumma as opposed to atrophic rhinitis; also the tenderness across the bridge of the nose is a most important point in diagnosing this condition from other intranasal ulcerations, *e.g.*, tubercle. It is not at all probable that the patient had any frontal sinus infection; he was not ill, as are patients with acute frontal sinus infections, and frontal headache is very frequent in gummatous ethmoiditis. It is, however, possible that a crust was obstructing the infundibulum (so causing mucus retention in the sinus), and the douche washed it away.

These three cases are examples of the most frequent tertiary syphilitic lesions met with in the nose.

The fourth case is that of a girl of 13. She was referred from the Ophthalmic Department with the diagnosis of "internal ophthalmoplegia," due to congenital syphilis, and she had some hoarseness of fourteen days' standing. On examination, she was found to have adhesions between the septum and middle turbinals on both sides, and the lower part of the nose was atrophic, with some crust formation. The history of the nose trouble was vague, but no doubt there had been ulceration in the nose of congenital syphilitic origin, and the adhesions were left as a result. In this case the result of the Wassermann test was negative, though there was no doubt clinically the case was syphilitic.

The next case is another showing the results of syphilitic ulceration in the nose:—

Violet L., aged 37, attended in the Out-Patient Department complaining of a right-sided nasal discharge of three months' duration. The discharge is yellow, occasionally blood-stained and of foul smell. She has also had frontal headaches for which she attended another hospital; she complained, too, of sore throat. She had a miscarriage one year ago.

The left nasal cavity was normal; in the right was a large crust about the middle turbinal, while the lower part of the cavity was wider than usual, as in an atrophic rhinitis. On removing the crust there was seen ulceration of the lower part of the middle turbinal and of the septum, and the middle turbinal was adherent to the septum. A small piece of necrosed bone was removed from the middle turbinal.

Examination of the pharynx showed a small typical ulcer on the left lateral wall, it was oval with the long axis vertical, there was a tone of vivid red round it, the edge was punched out and there was a grey slough on the floor. The uvula was a little œdematous and the upper aspect of the soft palate was thickened; she was seen again a few days later and the soft palate was now quite red and the patient had more pain; the disease was progressing rapidly. She was then given an intravenous injection of 606 and in three days' time the palate was again normal and the pharyngeal ulcer had well nigh healed.

The mouth and pharynx next claim our attention. I may preface this section of the subject by reminding you that constitutional syphilis manifests itself sooner in the mouth and pharynx than in any other part of the body. Chancre is very seldom seen in the mouth or pharynx; of the various possible positions the

tonsil is the most frequent, perhaps because in the act of swallowing the virus is pressed against the tonsils.

Secondary lesions.—The earliest is an erythema on the mucous membrane of the soft palate and isthmus of fauces and sometimes on the cheeks; it may give rise to so much reaction as to be called a "Syphilitic Angina" causing continuous dysphagia. Later the generalised erythema disappears and is localised to the tonsils anterior pillars and uvula. This erythema about the anterior pillars of the fauces as you see may be due to an early stage of secondary syphilitic lesions or may be the last remains of a secondary pharyngitis. This erythema of secondary syphilitic pharyngitis progresses to the formation of mucous tubercles and superficial ulceration of the fauces and tonsils. This superficial ulceration is often given the name of "snail-track" ulceration, a most expressive term, as its appearance closely resembles that of the slimly track of a snail. This patient, a woman aged 26, has had a sore throat for six months and her voice has become husky during the last fortnight. You will see that the tonsils are inflamed as are the anterior faucal pillars, and there is a greyish pink symmetrically disposed heaping up of the mucous membrane over the same area. This was a mild case and later got rapidly well under treatment with mercury.

The following case is another example though a somewhat unusual one:—

Minnie V., aged 22, was sent to the Out-Patient Department by Dr. Edwards; there was a definite history of congenital syphilis given by an Orphanage from which the patient was sent out to domestic service. She had had a sore throat for three weeks, with swollen glands about the angles of the jaw. The tonsils were large and had on them a greyish exudate; this was not quite typical of secondary syphilis as fairly energetic antiseptic gargles had been given: however, the Wassermann reaction gave a positive result. About three months previously the patient had slept with her sister, who is said to have had the same condition, and after this the symptoms appeared.

The girl was given an intravenous injection of neosalvarsan and got quite well in a very short time. This girl seems to have become infected (? by her sister in some way) though she suffered from congenital syphilis.

The following case is one where there was a simple erythema symmetrically disposed on the anterior pillars of the fauces as the only pharyngeal manifestation of secondary syphilis, though there were other typical signs of the disease about the body.

A woman, aged 31, attended the Throat and Ear Department complaining of hoarseness of three or four weeks' duration. On the inner side of her cheeks and lips were typical heaped up mucous patches, the pharynx showed symmetrical hyperæmia on the anterior pillars just above the tonsils, and the larynx was hyperæmic. She had a fading erythematous rash on her chest and arms, and condylomata about the anus. In this patient the secondary manifestations in the pharynx were not distinctive of syphilis, had it not been for the mucous patches on the cheeks the diagnosis would not have been certain.

We now pass to the tertiary, or rather gummatous, manifestations in the pharynx; under this head we find a large number of cases both acquired and congenital. The lesions found are gummata and they occur in many positions, the posterior pharyngeal wall, the lateral wall, the soft palate, and the hard palate. Like gummata in other parts they begin as a swelling which soon breaks down, forming a circular or oval ulcer with punched out edge, a so-called "wash leather" slough on the floor, and surrounding this a markedly hyperæmic area. Later, when healing takes place scarring results, often with considerable deformity of the parts; this scarring may be confined to the posterior pharyngeal wall, or may involve the pharyngeal wall and soft palate; the palate becomes fixed to the pharyngeal wall shutting off the nasopharynx to a greater or less extent. Sometimes the bones of the spine and base of the skull are involved, and sequestra may come away exposing the dura mater. When the hard palate is involved the whole of the horizontal plate of the maxilla may come away. The time after infection at which gummatous ulceration occurs varies from a few months to several years.

The following cases are examples of pharyngeal gummata.

The first is one of gumma on the posterior pharyngeal wall:—

A man of 47 attended the Hospital in February, 1914. He gave this history: three months ago he began being troubled with a cough, and two months ago a discharge began from the right ear with pain referred to the back and top of the head. His throat had been sore for the same time, and for the last month he had had nasal obstruction and a purulent discharge. He had been able to eat no solid food for two months on account of the pain on swallowing. On the posterior pharyngeal wall was an ulcer, oval in shape, lying mostly above the level of the soft palate though its lower end could be

seen on looking straight into the mouth, the surrounding parts were red, the floor was grey-white, and the edges were clean cut. The diagnosis was obvious and the Wassermann test was positive, and the patient was given potassium iodide, gr. x. t.d.s. In three days the patient's symptoms had completely gone and he could swallow well. When seen about four months later there was no trace of any ulcer or any scarring to indicate the position of the previous ulcer.

The next case is one of severe palatal ulceration :—

A man of 27 attended the Out-Patient Department for "sore throat" of three weeks' duration ; he had been in the army and had had a chancre in 1910. For this he had been treated with mercury injections, receiving altogether, between 1910 and 1912, twenty-seven doses. There was much reddening of the right side of the soft palate and the right tonsil region. In the midst of this area was a severe ulceration, partly on the palate, partly on the tonsil and anterior pillar; the floor showed a typical wash-leather slough. The man looked ill and had great pain on swallowing. He was given an intravenous injection of salvarsan (·6 gram.) and soon improved. The hyperæmia first diminished, then the ulcer lost its depth, and finally the whole palate returned to normal.

The case presented this interesting feature : in spite of twenty-seven mercury injections, the gummatous ulcer had appeared within seven months of the last injections, and was very severe and rapid. Notice, too, that the gumma appeared about three and a half years after the primary infection.

A woman of 33 attended in 1913 suffering from severe ulceration of the soft palate uvula and tonsil. She should have had salvarsan but felt ill and did not attend again till February, 1914. In the meantime she had had a miscarriage, and her throat which had previously improved under Potassium Iodide and mercury was worse again. She was given an intravenous injection of salvarsan and got well in a few days.

As a contrast to that case is the following :—

A woman of 25, had ulceration and perforation of the hard palate. In spite of this she had three healthy children.

The next two cases are good examples of the results of gummatous ulceration.

A man of 66 complained of deafness : on examination he was found to have complete nasal obstruction, and there was much muco-pus in both sides of the nose; the pharynx was scarred and the soft palate was as it were drawn up and adherent to the posterior pharyngeal wall completely shutting off the nasopharynx. The tip of the nose had fallen in, and the anterior part of the septum contained no cartilage, but was composed simply of mucous membrane. The patient had had a chancre 35 years previously, and his throat was "very bad" 12 months later.

It was remarkable in this case that the complete obliteration of the nasopharynx had not produced more symptoms in connection with the Eustachian tubes; the man certainly was deaf, but he heard low notes wonderfully well, his lower tone limit was G_1 (50 vibrations a second) ; his perception of high tones was greatly lessened, the upper tone limit being only 11,000 vibrations a second; and this limitation of the upper tone limit is usually associated with nerve deafness.

The second case exemplifying the result of scarring is that of a girl of 15. The patient was the subject of congenital syphilis, and had interstitial keratitis and iritis. For about a fortnight before attending she had noticed that, while eating, food returned through her nose. In the soft palate were two perforations close together, each about half a centimetre in diameter, the surrounding mucous membrane was a little red, the posterior pillar of the fauces on the right side was scarred and adherent to the posterior pharyngeal wall, the anterior pillar was perforated. No doubt as a result of imperfect drainage of the naso-pharynx the right ear was suppurating. This patient was given salvarsan and improved considerably though the perforations remained.

Sometimes the scarring after a gummatous pharyngitis constricts the pharynx so much as to interfere with deglutition and respiration.

Before considering the laryngeal lesions, I wish to bring to your notice two cases of late results of gummatous affection of the tongue.

The first case is that of a woman, Eliza F., aged 59. She attended the department in October, 1913, on account of nasal obstruction. This was due to a polypus. While she was still an out-patient she developed an ulcer on the left side of the soft palate, deep and punched out—a typical gummatous ulcer. This healed well with potassium iodide and mercury. The tongue was in the condition known as geographical tongue; the dorsum was divided into small irregular islands separated by deep fissures, and all over the central part the papillæ were absent, leaving the tongue quite bald; in addition, the tongue could not be protruded from the mouth. The patient had

peritonitis just before she was married; she had had no children and no miscarriages.

The second case is that of a man of 55, Ephraim T. He had syphilis thirty-five years ago; seventeen years later he "woke up one morning to find his tongue twisted to the left." On examination, the left half of the tongue was found to be very wasted. Held between the finger and thumb, the left half of the tongue appeared to be composed only of mucous membrane; the right half was quite normal. The patient's doctor subsequently told me there had been a deep gumma of the tongue.

At the time of his attendance at the Out-Patient Department, the patient complained of an unpleasant smell in the nose and parosmia; examination of the nose revealed no abnormality and a tentative diagnosis of delusions of smell was made. Subsequently the symptoms disappeared.

As a point of interest it may be noted that the previous case—that of the woman with the geographical tongue—also developed delusions which were those of persecution in her case.

(To be continued.)

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—At this time every man who has not had the opportunity of joining the Expeditionary or Territorial forces is thinking how he can be of some use to the military service of the country while still going on with his regular work. I would suggest to the students of this Hospital that they can best do this by joining the O.T.C. for the following reasons:—

1. If they are within an appreciable distance of qualification some training in military organization, however slight, will be of value to them supposing they take a commission in the R.A.M.C. on qualification.

2. If there seems to be no chance of their becoming qualified during the period of the war, it may happen that the number of hospitals attached to the expeditionary force will be considerably increased; in such a case medical students who have had some military training will be of the greatest value as nursing orderlies. Fifteen such men of this section have already joined the No. 2 General Hospital of the 1st London Division T.F.

3. Even though men have to stay at our own hospital—as will happen in the case of many—such military training will not be wasted. It is very possible that a large number of wounded will be taken into the civil hospitals; these men will be used to a military organization, and it will be distinctly useful if those who have to deal with them are used to a military routine.

By command of Lt.-Col. Sir Wilmot Herringham all members of the medical unit will in future wear uniform during the day. In this way cadets will show that they are giving up their spare time to perfect their military training, and will set a good example to others, thereby persuading them to join.—I am, dear Sir, yours faithfully,

T. B. LAYTON, Capt. R.A.M.C.(T.),
O.C. "B" Section Med. Unit,
Univ. of London O.T.C.

Guy's Hospital,
12th August, 1914.

Some Points in the Treatment of Syphilis.

By C. H. MILLS.

Read before the London Dermatological Society.

C. H. Mills read a paper entitled "Some Points in the Treatment of Syphilis" in which he said:—

Before commencing to read to you this paper, I would like first to express my appreciation to the Committee for the honour they have thus conferred upon me—one of the younger members of this society.

In the short space permissible for a paper of this description my endeavour will be, so far as possible, to touch upon certain points in the management of syphilis in general, points concerning which many recent advances have been made, and upon which great diversity of opinion exists. As such they should be of a certainty the better calculated to stimulate much interesting discussion, and to entice an utterance of the opinions of the authorities present, opinions so enhanced in value by a wide experience.

Up to the present date man has failed signally to check, in any material way, the incidence of syphilis. It is not my intention, however, excepting perhaps for a few remarks in passing, to devote any space in this paper to the subject of prophylaxis. That prevention is better than cure is not peculiar to syphilis, neither is the fact that the tendency exists to devote time, money, and research in the attempt to eradicate the effects rather than the cause. Chiefly then, since there is at present a Royal Commission engaged upon its prevention, and again because it is not the subject of this paper, I shall pass over the inoculation of syphilis. Assuming that the State is at present unable to prevent, or even control, the inoculation of syphilis in general, the responsibility of the medical profession is magnified, from a sociological aspect, in that to it alone the laity look for an ever-progressive eradication of this national scourge until the goal of infallible cure is reached. Therefore, in treating upon the management of syphilis, I shall commence from the termination of the incubation period, as evidenced clinically by the appearance of the primary sore. It will not be out of place here to say a few words upon the early diagnosis of syphilis.

Every day it is being more forcibly driven home to us that the greatest factor controlling the ultimate success in the treatment of a case of syphilis is the period of time allowed to elapse after inoculation before treatment is commenced. It is, therefore, of the utmost importance that the physician should be able to detect the presence of the *Spirochœta pallida* in the primary sore, at the very earliest possible hour. To-day the responsibility of having to give an opinion upon the nature of a sore, possessing the possibility of being venereal in origin, based purely upon its clinical characteristics, is removed from us. The ultra-microscope combined with more

recent improved methods of staining specimens, has rendered it possible for one to arrive at a positive diagnosis, frequently within the first few hours after the discovery of the lesion, and so to give a definite opinion with an easy conscience.

If relying upon clinical evidence alone, no man is justified in giving an opinion as to whether a sore is syphilitic or non-syphilitic until, in some instances, after the period has elapsed at which possible secondary symptoms should have developed. True, some primary sores are typically indurated at a very early date, but even then one has usually to exclude the amount of local reaction produced by various local applications.

It is always easier to decide clinically that an early sore *is* syphilitic, than to be able to guarantee definitely that one *is not* syphilitic, and this is only possible in an unmixed infection. That is to say, the so-called "soft sore" so frequently develops later into the hard chancre. In a case of mixed infection the ulceration and resultant loss of tissue produced by *S. refringens* and Ducrey's bacillus, is in excess of the more slowly developing zone of induration indicative of the presence of *S. pallida* that the latter phenomenon may be masked for some time.

However, thanks to the greater publicity of the danger of neglecting to seek early medical advice, the cases are becoming fewer and fewer, in which the physician is justified, in withholding anti-syphilitic treatment, while, to use the old-time expression, he "waits for the rash to appear." It is only in such cases as these, viz., those in which the sore has dried up that the Wassermann test is of any service in the aid to an early diagnosis, and thereby the abortion of secondary manifestations made possible. It is in the *diagnosis* of syphilis that such rapid strides have been made during the past few years, directly resultant from Schaudinn's discovery, and Hoffmann's subsequent isolation of *S. pallida* in all active syphilitic lesions. It is the duty of every physician who is consulted regarding the nature of a sore, no matter how trivial, to avail himself of one of the numerous methods now at his disposal for ascertaining the presence of the *S. pallida* should syphilis be suspected.

For instance, in a problem such as that, where the patient presents himself after the sore has practically healed, fluid obtained from a puncture of the adjacent lymphatic gland, might possibly reveal the presence of the *S. pallida* several days earlier than would the Wassermann reaction.

Undoubtedly the dark ground illumination is the most accurate method of detecting the *S. pallida* in that by this means the spirochæte can be studied in its living state, and its movements observed. It is by its movements that *S. pallida* differs most markedly from its fellows. Hence, in examining material taken from lesions in the buccal cavity, this method is indispensable, since the *S. dentium* resembles *S. pallida* so minutely in stained specimens, that an opinion can only be given after observing the marked difference *in vivo*. Apart from being the most accurate, it is also the simplest and most rapid means of examining suspected material.

However against this method, from a practical point of view, must be mentioned the following two limitations: firstly, a microscope must always be set aside and adjusted for this particular work, and we do not all of us possess two microscopes; secondly, it should only be employed by one thoroughly experienced in its use. No clinic should be without this means of diagnosis, and I believe that it is constantly employed at St. Peter's Hospital. Of the various methods in vogue for the detection of the *S. pallida* in film preparations, Burri's Indian ink method stands out alone for its simplicity and rapidity. It is a method I employ as a routine and have never yet met with a case presenting an open sore, in the which I was unable to demonstrate the *S. pallida* by this means after three or four separate searchings at intervals, which later proved to be syphilitic.

It is of the utmost importance that all local antiseptic applications should be withheld until a diagnosis is arrived at. The ideal dressing being simple fomentations combined with soap and water.

The coarse, blunt-ended *S. refringens*, with its few large irregular spirals, commonly met with in all ulcerating surfaces, ought never to cause any confusion. I have found that the addition of tincture of iodine to the Chinese ink I use (20 minims to ½ oz.) produces a better film with clearer definition, preventing the granular formation of the particles in the dark background.

Regarding the various processes in use for staining the *S. pallida* the methyl violet method is one of the simplest, quickest, and most reliable. In this method the spirochæte are stained *in vivo*. To obtain the best results with Giemsa's method requires twelve hours' staining. The important fact always to be borne in mind is, of course, that two or more fruitless searchings for the spirochæte whatever the method employed, does not negative the diagnosis of syphilis. Concerning certain observers who maintain that they are able to diagnose syphilis from the intracellular organism credited with representing a phase in the life history of the *S. pallida*, I am inclined to think that the possible sources of error must be greatly increased, granted that the theory should be generally accepted, and I seriously question if they can demonstrate the above at an earlier date than that at which the easily recognizable *S. pallida* can be detected. My own experience with Noguchi's intradermal luetin test, is that it is entirely unreliable in early syphilis, but is more constant than the Wassermann reaction in old standing cases. This is also the experience of Dr. Browning who has employed the two tests simultaneously in just upon 150 cases at Moorfields.

The date at which the Wassermann reaction becomes positive before the appearance of the secondary rash is very variable. I remember one case in which the reacton remained negative even though a faint roseola eruption was discernible. One can take it that on an average, the *S. pallida* can be obtained from the primary sore at least a fortnight to three weeks earlier than would the

Wassermann test reveal its presence. During the recent advances both on the diagnosis and therapy of this disease, but scanty attention has been paid to the local treatment of the primary sore. After the fact was once firmly established that total excision of the chancre in no way tended towards the abortion of the secondary manifestations, its local treatment lapsed back to the "black wash and mercurial ointment or powder" type of dressing again.

I maintain that the thorough eradication of the chancre immediately it has served its only useful purpose—that of the earliest source for diagnostic material—should be commenced, the reasons being the following :—

(1) A common source of infection to others is thereby removed.

(2) When the chancre can be removed by circumcision, preputial cicatrices are impossible.

(3) Suppurating inguinal glands so frequent to-day from this source would be very rarely seen.

(4) The devastating processes of phagedæna and the resultant deformities would be entirely obviated.

(5) That indolent type of serpiginous ulceration met with in the groin, following upon the breaking down and subsequent skin infection from the inguinal glands—now proved to be caused by an intracellular variety of Ducrey's bacillus—would never develop.

(6) The two cases now to be described will serve to illustrate the danger of permitting to remain untreated the residual nodule of partially organized induration tissue, which commonly marks the site of the original primary sore, in some cases for many months.

The first is the case of a patient whom I was treating at St. Peter's Hospital by weekly intramuscular injections of atoxyl alternating with mercury. His secondary rash, ulcerating fauces, and anal patches disappeared satisfactorily, but the chancre, a hard indurated mass, surmounted by a dry scab, remained obdurate. On the patient presenting himself for his weekly injection seven weeks after the disappearance of the rash, I noticed the subcutaneous tissues of the penis to be in a condition of syphilitic œdema, there being no mechanical paraphimosis or dropsy present to account for it. He stated that this had developed after he had removed the scab and squeezed the chancre until it bled, five days previously, with the intention of getting it to heal. Proceeding to examine him I found that there was a definite recurrence of his secondary rash and his fauces were again ulcerated. McDonagh has recorded three somewhat similar cases. What had clearly happened was that the sudden discharge of a shoal of *S. pallida* expressed from the sheltering zone of partially organized induration tissue into the already hypersensitized patient produced the reappearance of the secondary rash on the grounds of anaphylaxis, which is the best theory yet advanced in explanation as to when and why the phenomena known clinically as the secondary stage occur in the course of a typical case of syphilis.

The second case is that in which a patient consulted me, who, at the end of fourteen months' vigorous treatment, including two injections of salvarsan, still gave a positive Wassermann. He presented no evidence clinically of active syphilis apart from a slight thickening in the scar of the old sore. I removed the thickened scar under local anæsthesia and sections of the same revealed the presence of the *S. pallida* in the fibrous tissue. I am sure that this is the real explanation of the "recurrent chancre" described by Hutchinson.

We must have, all of us, frequently wondered why a gumma should elect to develop—sometimes as long as thirty years afterwards—at the exact site of the original sore, rather than appear in any of the other numerous localities so constantly exposed to injury.

The lines of treatment of the primary sore which I find the most effective are these : When possible, total removal should be carried out. That is to say, all preputial sores should be treated by circumcision. This is a very small procedure under local anæsthesia, the best dressing being a circle of gauze, emulsed in iodoform, tied around the wound by leaving the stitches sufficiently long. With sores situated where complete excision is not permissible, freezing for three minutes with carbon-dioxide snow dissolved in acetone, applied with a brush, after a suitable Bier's cup has made suction for ten minutes, gives an excellent result, the subsequent application being powdered iodoform, sulphur, and calomel, in rotation, on successive days. The slough is removed with hydrogen peroxide at each dressing. A daily injection of ·2 grm. of hectine should be given during the first week into the neighbourhood of the chancre.

Now some remarks upon the general treatment of syphilis. The reason why I have devoted so much space up to now upon the early diagnosis and subsequent treatment of the primary sore is, that upon this early diagnosis entirely depends the possibility of being able to bring about the abortive treatment of syphilis. By abortive treatment I mean the "nipping in the bud," so to speak, of an infection with syphilis, the bud, of course, being the primary sore. Only by this means can we anticipate and so prevent the development of the Wassermann substance within the host; at any rate, its production in sufficient quantity to bring about the inhibition of hæmolysis. I say sufficient in quantity because it is as yet unproven that the substance is not present normally in infinitesimal proportions. We know, with the appearance of the chancre, a gradually increasing filtration of the *S. pallida* into the blood-stream commences, those that have entered the blood-stream during the incubation period having probably succumbed to the spirillicidal properties possessed by the blood normally. That the blood can resist normally a temporary invasion of the *S. pallida* is adequately proved by the failure of attempts to inoculate apes with the same, direct into the blood-stream.

By commencing treatment at the very earliest hour not only is the patient in the best state physically to

withstand the most drastic treatment considered necessary, but also there is present a minimun number of *S. pallida* to be devitalized, and we know that whatever the drug we employ in syphilis we rely entirely upon its actual spirillicidal property.

Again, by this early treatment we are cutting short the infectivity of the patient within a few days and absolutely eliminating the affections of the mucous membranes in secondary syphilis—the most infectious of all syphilitic lesions. When the public are better educated with regard to seeking the earliest possible advice, and the abortive treatment a routine procedure, then, and then only, will the manifestations of secondary syphilis be almost as great a rarity as typhus fever to-day. Regarding the actual treatment, I find, up to the time of writing, the following to be the most efficacious :—

Three intravenous injections of ·9 grm. of neosalvarsan administered within the first fortnight, that is to say, an interval elapsing of six days between between each injection. Simultaneously with the neosalvarsan is given an intramuscular injection of ½ gr. of calomel.

One is, of course, guided by the tolerance of the initial injection as to the dosage, and, if necessary, postponement of the subsequent injections, but it is exceedingly rare, given thorough technique, to have to make any modification in the scheme described in the average adult, otherwise uncomplicated. The initial dose will be smaller in accordance to the type of individual. Patients tolerate both neo- and salvarsan more easily when they are given at this stage of the disease than in the later periods.

I follow up these injections with a rigorous course of mercury, combined at intervals with the iodides for at least one year. We all of us have our personal views as to the best means of administering mercury, and I always think that it is not so much the preparation used that matters, but the way that it is given. Personally, I consider argulan one of the most efficacious preparations, which, as you may know, is Hg dimethylphenyl-pyrazolone amino-sulphonate. I give calomel intramuscularly for the first three injections, since it is temporarily more effective than the other forms of mercury, but its influence is not so lasting.

Two years ago I began to doubt as to whether neosalvarsan was as powerful a spirochæticide as the original salvarsan.

About that time, however, I had occasion to treat a severe case of malignant syphilis. The shedding of rupial crusts into the bed during the day following his first neosalvarsan injection quite convinced me as to the equality of the two preparations, as did his subsequent progress.

However, in "stale" cases of syphilis I still think that the original salvarsan is the better for converting a persistent positive Wassermann into a negative.

Too much has been written upon the contra-indications to the administration of either drug for me to touch upon them here.

As previously stated, up to the date of the appearance of the chancre the quantities of the *S. pallida* which can have been disseminated through that unfavourable medium—the bloodstream—must be comparatively small. To wait until the *S. pallida* have pullulated in recesses most removed from the blood-stream, is as unscientific as it is unfair upon the patient and drug employed. Therefore by introducing salvarsan into the circulation at the very earliest we are giving that drug every chance of catching up with and annihilating the scattering *S. pallida* before they will have had time to filter through into umbrage beyond the reach of the systemic circulation. I refer, of course, principally to the cerebrospinal system, into which we know that salvarsan fails to penetrate through the choroid plexuses. It is as the ammunition for the first and critical attack that salvarsan most effectually surpasses mercury.

In those unavoidable cases in which the primary sore was never discovered by the patient, or when the patient neglects to present himself for examination until the general dissemination has occurred, possibly weeks, if not months, previously—then mercury will always hold its own against salvarsan. The most valuable property possessed by mercury, and the only one by which it surpasses salvarsan, is that it can be tolerated by the patient for months, even years, during the whole of which time sufficient quantity is present to have therapeutic power and so be capable of destroying such shoals of *S. pallida* as may be liberated from time to time into the circulation, and prolonging the latest phases.

Hence the most powerful effect is obtained by each drug when employed in conjunction, using salvarsan for the initial rapid scouring, and following up with mercury. While on the subject of these drugs I wish to discuss the value of the iodides in the early stages of syphilis.

The tendency exists to administer the above only in the latter stages of this disease. I give the potassium iodide during the early stage on the grounds of its power of promoting the absorption of small-celled infiltrations and imperfectly organized exudates. In lesions, therefore, such as much indurated chancres, large pustular and rupial eruptions, access to the harboured *S. pallida* may be the more facilitated for the salvarsan.

The elimination of arsenic is said to be aided when given in conjunction with potassium iodide to the same extent that the elimination of mercury certainly is in cases under long courses of mercury.

In those cases of early syphilis when nocturnal headache and periosteal pains generally are the chief symptoms complained of by the patient, potassium iodide relieves as if by magic.

In so-called "precocious" syphilis in which the early symptoms resemble in character those of the tertiary period, potassium iodide is indispensable. The tendency to lower the blood pressure is beneficial in active syphilis in a working man just as one would strictly prohibit any

vigorous exercise or excessive strain in a private patient suffering from early syphilis with the main object of minimising any cardio-vascular stress. The circulation of toxins is retarded and undue strain on the larger arteries avoided.

My experience, based upon upwards of 950 injections, is that the second injection of 606 should always, when permissible, be given at an interval not exceeding eight days. The most marked reactions that I have encountered have all followed the second injection when this interval has been exceeded. The phenomenon may possibly be attributed to anaphylaxis. Regarding the present tendency to give the highly concentrated solutions of neosalvarsan by means of a serum syringe intravenously, I prefer the dilution of a 200 c.c. solution for the early injection, when one has little or no time to ascertain the presence of any possible idiosyncrasy as to the tolerance of arsenic.

I am at present treating some cases of tertiary syphilis by means of weekly intravenous injections of small doses of neosalvarsan, given by means of a simple serum syringe, but it is too soon yet to form an opinion.

In four cases of maternal syphilis, in all of which the previous pregnancy resulted in a syphilitic fœtus, I have had capital results with neosalvarsan. In each instance the injections were given between the third and fourth months of pregnancy and resulted in the production of a healthy full-term child. With the exception of one case, in which the mother unfortunately overlaid the child when a week old, they are all living and show no syphilitic taint to date. Apparently there is no risk of salvarsan producing abortion such as occurs when mercury is pushed to excess during pregnancy.

In children under the age of 10 I always administer neosalvarsan by slow rectal infusion through a No. 10 gum-elastic catheter. The drug is quite efficacious when given in this way, a slightly larger dose being required than in the intravenous method. It is readily absorbed and does not produce proctitis with ordinary precautions.

I have also employed this method in cases when the intravenous root has been contra-indicated. Two cases of tabes I have treated by taking diluted serum abstracted from the patient's blood one hour after an intravenous injection and introducing same into the spinal canal, as first suggested by Swift and Ellis. They are both doing very well and have had no lightning pains or crises since the injections, four months ago. The following points may be of use concerning the actual introduction of the needle into the vein for intravenous injections. As you will all agree, this can be exceedingly difficult in certain cases, such as in obese subjects or where the veins are poorly developed. If the veins at the anti-cubital space are selected the arms should be immersed for a quarter of an hour in water as hot as can be borne by the patient. If the internal saphenous vein just above the internal malleolus of the ankle is chosen, the leg can be conveniently placed in a bucket. In the case of the arm, it should be then swung round, windmill fashion, for five minutes and hung in a dependent position as the patient reclines upon the table. While all muscles are relaxed the tourniquet is now applied, care being taken by feeling the pulse that no more pressure is being exerted than that necessary to occlude the venous return. The commonest mistake made is to apply the tourniquet too tightly, thereby preventing the arterial flow into the part. Care should be taken not to insert the point of the needle into a valve, the position of which can usually be located. After having tried various forms of tourniquets I am convinced that a simple piece of rubber tubing gripped by a pair of Spencer-Wells forceps is the best, its removal when required being instantaneous. By lubricating the needle with a little sterile vaseline its passage through the skin is greatly facilitated, especially when iodine has been used for the sterilization of the skin. Another small but important point in making the entry of the needle into the vein is that the point should be run parallel to the same for half an inch before puncturing its wall. By employing the above mentioned schemes I have never yet been compelled to cut down upon a vein.

In conclusion, I would just like to add a few suggestions as to the treatment of chronic interstitial glossitis. Internally I find the intensified iodine treatment very effective when combined locally with Bier's passive hyperæmia, produced by means of an elastic band placed as far back as possible around the base of the tongue. This should be applied for twenty minutes t.d.s. For the usual accompanying areas of superficial glossitis I have used emulsion of neosalvarsan in glycerine as suggested by Dr. Allport with good results. For localized ulcers a Bier's vacuum cup, combined with pig. acidi. chromci., is very efficacious.

The Services.

It has been suggested that a few notes concerning the various services—naval, military, and civil, that are especially open to recruits at the present time, would not be out of place in the Gazette. It is greatly to be hoped that qualified men and students alike who are able to be released from their work at the Hospital will, as far as possible, join units in which their medical training will not be wasted, leaving the executive branches to men who have not had the advantages of a specialized training. Men within a month or two of being qualified in the ordinary course of events are strongly advised to try and become qualified at the earliest possible opportunity when they are likely to be of very much greater service to their country.

(1) For Qualified Men.

Royal Navy.—There are vacancies for men anxious to serve as naval surgeons. Employment may be afloat or ashore. Enrolment for a short period or until the end of the war. Good pay and allowances.

Vacancies are also likely to occur for special service on armed merchantmen, etc.

Army.—There are vacancies in the Royal Army Medical Corps. Men who have had previous training in the medical or other branches of the Officers' Training Corps, and so have some knowledge of army work and organization, are particularly suitable for this service. Terms of service, etc., as in the Royal Navy.

Men may also enrol for special work at home, such as duties in the military stations for civil work while the regular officers are otherwise engaged.

(2) For Unqualified Men.

Royal Navy.—Men who have passed their 'intermediate' examinations are available for service as dressers. They will be required to undergo training for a short period at a naval hospital and will thence be drafted for service afloat or ashore according to needs at the time. They will rank with sub-lieutenants and receive pay and allowances as such. Terms of service as for naval surgeons. Full particulars may be seen in the Colonnade or the Club Library. This service is particularly suitable for men who have had no military training.

Army.—Men may be required later as dressers at base and general hospitals. Those having had some army medical training as in the O.T.C. will have preference over those who have not.

Members of the Officers' Training Corps are serving in No. 2 General Hospital at the Duke of York's Territorial Headquarters, Chelsea, under physicians and surgeons drawn from this and other hospitals.

Officers' Training Corps.—It is hoped that as many men as possible who are unable to give up all their time to military work or to leave the Hospital will join the medical branch of the O.T.C., so that they may acquire some knowledge of military organization and R.A.M.C. work—stretcher drill, etc. This is very specialized work, and men who have some knowledge of it will stand a much better chance of quick employment later if called upon to join the R.A.M.C., etc. Drills and lectures will be held daily at Guy's for the present, and Orders will be posted in the Colonnade. Particulars as to joining, length of service, etc., may be obtained from Capt. Layton.

(3) Special Constables.

Large numbers of men are wanted to enrol as special constables, who will be required to serve in plain clothes for four hours a day. Duties will be arranged as far as possible so as not to interfere with other work and to take place near the individual's home. Further particulars as to this service will be seen elsewhere in the Gazette. Only men in the medical wards or who have not yet left the Medical School are advised to enrol as constables.

Change of Address.

Dr. G. Harcourt Peall, to c/o R.N.L. Bureau, Salisbury, S. Rhodesia.

P. P. Laidlaw, Esq., B.C., from 38, Gubyon Avenue, Herne Hill, S.E., to 85, Prince of Wales' Mansions, Battersea Park, S.W.

Appointments.

Medical School Appointments.

Revised List.—July–September, 1914.

As from 10th August, 1914.

Clinical Assistants.—Messrs. L. Muir-Smith, H. P. Whitworth, C. Dean, C. Lambrinudi, F. E. R. Laborda, and P. D. Scott.

Clinical Assistants in Medical Wards.—Messrs. W. M. Lansdale (Dr. Hale White); L. R. Pickett (Dr. Shaw); H. L. Messenger (Dr. Beddard).

Clinical Assistants in Surgical Wards.—Messrs. D. O. Richards (Sir Alfred Fripp); N. H. W. Saw (Mr. Steward).

Dressers and Clerks in Special Departments:—

Throat and Ear, Genito-Urinary, and Children.—Messrs. J. E. Clark and J. G. Stevens.

Throat and Ear, Skin, and Orthopædic.—Messrs. M. J. T. Wallis and G. B. Tarring.

Eye and Nervous System.—Messrs. A. L. Punch, G. S. B. Long, W. A. Young (Mr. Eason); C. E. Petley, J. Stephenson and C. de W. Gibb (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. C. C. G. Gibson, A. F. Rook, M. Chadwick, J. F. H. Stallman, R. A. Holmes, R. Curle, L. R. Broster, K. L. Bates, R. W. P. Jackson, N. E. Kendall, E. W. Bowell, E. J. Cooke.

Medical Ward Clerks and Post-mortem Clerks.—Messrs. A. Traill, A. D. Marston, A. W. Cocking (Dr. Hale White); J. B. Fairclough, M. Pearson, W. D. Newland (Dr. Shaw); E. C. de M. Morgan, A. G. East (Dr. Fawcett); E. M. Litchfield, E. S. Bowes (Dr. Beddard). E. N. Glover, W. J. Vance, G. E. L. Simons, H. J. Bensted, and D. V. Halstead.

Surgeons' Dressers.—Messrs. V. R. Hirsch, J. E. de Robillard (Sir W. Arbuthnot Lane); F. A. Knott, C. H. Edwards, V. E. Lloyd (Mr. Dunn); D. H. A. Galbraith, H. M. Gray (Sir Alfred Fripp); K. N. Purkis (Mr. Steward).

Assistant Surgeons' Dressers.—Messrs. I. R. R. Brogden (Mr. Fagge); P. G. McEvedy (Mr. Rowlands); D. M. P. Whitcombe (Mr. Turner); W. H. A. Pratt (Mr. Hughes); W. G. S. Neely (Mr. Davies-Colley).

Surgical Ward Clerks.—Messrs. T. E. Micklem, G. Sterne-Howitt, M. C. Joynt, A. L. Ahmad, R. Aspinall-Stivala, M. B. M. Tweed, I. Tewfik, E. S. Phillips, S. Vidôt.

Pathological Assistant to the Demonstrators of Morbid Anatomy.—Mr. D. O. Richards.

N.B.—Students are requested to serve as appointed above. If changes are desired or necessary, please communicate with the Medical School Office.

Bernard Isaacs, L.D.S. Eng., Hon. Dental Surgeon to Cape Town Jewish Orphanage, South Africa.

Graham Poock, Dental Surgeon to the Military Hospital, Dorchester, and Dental Surgeon to the Dorset Constabulary.

Dr. G. Harcourt Peall, appointed Medical Officer to the Rhodesian Native Labour Bureau.

University of London Officers' Training Corps.

Medical Unit. "B" Section.

Section Orders for the Week ending Saturday, August 22nd, 1914.

1. *Extract from Unit Orders of August 9th.*—"Cadets will wear uniform during the day."

2. *Transfers.*—The following cadets of the section have enlisted in the Territorial Force for service with No. 2 General Hospital (City of London), 1st London Division:—

J. A. M. Alcock.	W. W. King-Brown.
W. McB. Allan.	K. F. McAlpin.
R. Aspinall-Stivala.	R. H. C. Pryn.
G. W. J. Bousfield.	G. A. Sims.
J. F. Carter-Braine.	W. A. Turner.
P. G. G. Davis.	S. Vidôt.
St. G. D. Gray.	E. M. Webster.
C. T. Helsham.	

3. *Parades, etc.*

9.25 a.m. daily (Sunday excepted).—Squad and stretcher drill.

12 noon daily (Sunday excepted).—Bandaging and first aid class.

4.30 p.m. daily (Saturday and Sunday excepted).—Lecture in the Anatomical Department.

Monday and Thursday.—Col. James: The work of the R.A.M.C. Units.

Tuesday, Wednesday, and Friday.—Capt. Layton: Administration and Organization. Military Hygiene.

2 p.m., Saturday.—Field Work in the Park.

All parades and lectures are compulsory. Anyone wishing for leave off must apply to the Orderly Sergeant before the parade.

4. *Additional Training.*—Classes in military law will be announced shortly.

Cadets having no ward work to attend to will apply daily to the Orderly Sergeant after morning parade to be told off to other work.

5. Section Orderly Sergeant: Sergeant Stephenson. Acting Section Orderly Corporal: Cadet Kidman.

T. B. LAYTON, Capt. R.A.M.C.(T.)
O.C. "B" Section Med. Unit,
Univ. of London O.T.C.

Guy's Hospital, S.E.
14th August, 1914.

Reviews, etc.

Defensive Ferments of the Animal Organism. By Emil Abderhalden. (Bale, Sons & Danielsson, Ltd.) Price 7s. 6d. net.

The first part of this book consists of a brief but very interesting sketch of the methods by which the body deals with substances entering the blood-stream, either from outside the body or from the various organs; this is followed by an account of the author's observations on the new ferments appearing in the blood of animals after the injection of proteins, fats, or carbohydrates. Similar tests were then employed to show the reaction of the maternal organism to the new protein entering the circulation from the chorion, and the method was found to be applicable to the clinical diagnosis of pregnancy. The principles of the method has been dealt with in an article in a recent issue of the Gazette. A number of reports from different German laboratories upon the practical value of the test were quoted in the *British Medical Journal* of May 23rd last; the opinions expressed were on the whole very favourable. The pregnancy reaction can be applied also in the diagnosis of cases of chorion-epithelioma, as in the case reported recently by Williamson and Noon to the Royal Society of Medicine.

The line of research originated by Abderhalden should have very numerous applications in physiology and pathology, and the ideas which it suggests are put forward in profusion in this book. The method as applied to malignant disease might be of great value in providing the earliest possible diagnosis; since the reaction to the products of the chorion is perceptible within two or three weeks from conception, one would expect that ferments acting on a new growth would in most cases be present long before the patient was led to seek medical advice. Possibly in the near future apprehensive persons will have their serum tested once a month against a polyvalent carcinoma-sarcoma peptone mixture, in which case chemical pathologists will be indebted financially to Professor Abderhalden as are bacteriologists to Sir Almroth Wright.

The latter part of the book contains an account of the technique employed. We are told that "no one should deal with pathological cases by means of the dialysation method, and the optical method, who has not given evidence of having been able to produce 100 per cent. of correct diagnoses from pregnant, and particularly from non-pregnant, individuals, using placenta as his substrate. Should the technique of the student be found wanting in this branch of practical application, then it is quite certain that he has not mastered the method, and no special investigations should be undertaken without such a certificate of capacity." In other words, the method in competent hands is absolutely, and without exception, reliable, and not one of the other workers who have published their results was justified in doing so, since they appear all to confess to not less than 2 per cent. of incorrect diagnoses, and would, therefore, be excluded from Professor Abderhalden's pass list.

After reading of the numerous possible sources of error in the dialysation method, one turns to the account of the polarimetric method in the hope of finding something easier. No data whatever are given to show the amount of rotation which occurs in a positive case; this section would have been improved by the inclusion of the protocols of some actual experiments.

The translation is singularly infelicitous; the pages are haunted by the very recognizable ghosts of German

phrases and idioms. It is to be hoped that the dreadful phrase "dys-function" will not come into general use.

The book concludes with a bibliography of two hundred and twenty-nine publications, of which exactly one hundred bear the name of Emil Abderhalden; whether this round number is the result of chance or of moderation is not stated.

Aids to Dental Anatomy and Physiology. Third edition. By Arthur S. Underwood, M.R.C.S., L.D.S. (Baillière, Tindall & Cox.)

We must congratulate the author on having brought his splendid little book up to date. The chapter on enamel is excellent. We do not advise cram books as a rule, but this is really something more, being one of the most interesting little books on the subject that we have read. It seems to us, however, a great pity that the author has omitted the chapter on microscopy which was one of the great features of the past editions, nevertheless we can heartily recommend the book as good reading for men starting Dental Anatomy, and for qualified men wishing to revise it.

Dental Microscopy. Third edition. By A. Hopewell-Smith, L.R.C.P., M.R.C.S., L.D.S. (John Bale, Sons & Danielsson, Ltd.) Price 15s. net.

We congratulate the author on the popularity which justifies the third edition of his well known book. The period which has elapsed since the last edition was published has been marked by many new methods, and these are all lucidly brought forward in this volume.

We see he recommends the employment of a saturated solution of dextrose in preference to gum mucilage (B.P.) for imbedding.

It is rather surprising to see in the chapter on the preparation of the hard tissues, the remark that the best decalcifying fluids are hydrochloric, nitric, picric, chromic, acetic, and arsenic acids, and that they are enumerated in the order of their importance and usefulness. We should have thought that such an acid as formic acid ought to have had a more prominent position instead of being casually mentioned at the end of the chapter.

It is interesting to see in writing on the absorption of teeth that he uses the words "absorbent tissue" in place of absorbent organ which we think is quite justified.

The book can be heartily recommended, not only for men "up for the final," but also for men in practice who want to do research work and dental pathology.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital Cricket Club.

The following are the results of the 1st XI matches of the past Season.

Ordinary Matches.

Opponents.	Played at	Result.
Beckenham	Beckenham	scratched
H. A. C.	H. O. P.	lost by 8 wks.
Hampstead	H. O. P.	lost by 33 runs
Granville	H. O. P.	won by 31 runs
Sutton	Sutton	won by 10 wks.
Surrey Club & Gr'nd	Oval	lost by 103 runs
Bexley Asylum	Bexley	scratched
Beckenham	H. O. P.	scratched
Seven Oaks	Seven Oaks	lost by 12 runs
Crofton Park	H. O. P.	won by 141 runs
Thespids	H. O. P.	won by 6 wks.
Hampstead Nomads	H. O. P.	scratched
Cane Hill Asylum	Cane Hill	won by 7 wks.
Hampstead	Hampstead	lost by 77 runs
Bromley	H. O. P.	lost by 55 runs
Forest Hill	H. O. P.	scratched
Wanderers	H. O. P.	drawn
Thespids	Malden	lost by 89 runs
Granville	Granville	won by 7 wks.
Past	H. O. P.	drawn
Forest Hill	Forest Hill	won by 163 runs

Inter-Hospital Cup Competition.

Opponents.	Played at	Result.
Bart.'s	Chiswick Park	abandoned
Bart.'s	H. O. P.	won by 2 wks.
St. Mary's	Hale End	won by 10 wks.
London (Final)	Hale End	won by 205 runs

Guy's Cricket Tour.

During the third week in July a tour was held in Bournemouth, which proved to be very successful both socially and from a cricket point of view. This is the first tour that has, as yet, been arranged with any success, and we trust that many more such will be arranged in the future. Five matches were played, two won, two lost, and one abandoned through rain.

v.	The Trojans	at Southampton	- lost by 116 runs
v.	Blandford	at Blandford	- abandoned
v.	Poole Park	at Poole Park	- won by 57 runs
v.	Bournemouth	at St. John's	- won by 90 runs
v.	Ringwood	at Ringwood	- lost by 50 runs

Result of all Matches.

Played.	Won.	Lost.	Drawn.
25	12	9	4

Birth.

WEBSTER.—On July 30th, at Ty Gwyn, Merthyr, the wife of Vivian Webster, of a son.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

AN attempt was made in the last issue of the GAZETTE to point out the danger of a shortage of House Officers, owing to the War. It reflects great credit on the *esprit de corps* of the Residents that so many have remained at their posts quite voluntarily, and without pressure of any sort from the Hospital authorities. Doubtless some of them may feel great qualms of conscience when met by friends, ignorant of the hospital and its work, who cannot understand why they are not at the front. Such anxiety is quite unnecessary, as a few words of explanation would quickly dispel the doubts of their friends, who must be taught that in some instances it is easier to neglect one's own work rather than to carry it on efficiently through a great emergency.

IT has always been the policy of Guy's Hospital to work silently and efficiently out of the glare of publicity. At this juncture such a silence is a sign of great strength—certainly not one of weakness, for it shows a firm foundation which does not require any kudos from self-advertisement. Owing to the foresight of the authorities, only a certain proportion of the Staff hold commissions in the Territorial Force. The others sacrifice their ambitions in order to deal with the extra work placed on them.

THE traditions of the Hospital have been admirably carried out with excellent results. A perusal of the incomplete list of present Guy's men on active service, published in this issue, gives ample evidence, if such be needed, that, as in the South African War, our fellows are always ready for duty. What is more, they go to their duty with light hearts, because of the self-sacrifice of their colleagues who remain here to carry out their work, in many cases to their own personal disadvantage.

THE departure of a Guy's Contingent of Red Cross Nurses last week shows that the same patriotic spirit animates the feminine element of the Hospital. A correspondent sends us the following, which was heard in St. Thomas's Street last Monday week:—

First Boro' woman: "That's not one of 'our' nusses."

Second Boro' Woman: "Course it is, she's got on army togs, but don't yer know a 'Guy's face' when yer see it."

Both: "Good luck to yer nurse."

OWING to the loyalty of the Staff, Residents and Students, the sick civil population, which has increased rather than diminished, is being treated quite as efficiently as it was before the war. Furthermore, we are able to deal with the extra out-patients' coming from other Metropolitan Hospitals which are now closed.

The Cadets of the Officers' Training Corps, under the care of Colonel James and Captain Layton, are making excellent progress. Junior men from the Dissecting Room and a contingent of the Officers' Training Corps from Cambridge have entered the wards. The former need no fresh welcome; the latter we greet for the first time, and trust that they will become imbued with the spirit of Guy's, and not leave until their names are added to that great list of men which this Hospital has contributed to the medical profession. The Clubs' Union welcomes them as Honorary members, and hopes that they will find time to go down to the ground at Honor Oak Park, even in these strenuous days.

The large number who have entered bears a striking testimony of the efficient working of the Hospital. In addition to instruction in Surgery received from the Staff, Sister Margaret, the Assistant Matron, is giving lectures on Nursing, and the Sisters in the Surgical Wards supervise practical training in the management of sick patients. We have heard many amusing accounts of the heroic efforts of mere man to wash a patient without missing the corners. But seriously, this is an excellent innovation which should be continued as part of the regular curriculum.

In a short time a body of men will be available who have, by practical experience, got rid of inhibition and shyness, and so will be of real use if called upon as orderlies.

We print the replies to the letters from the Superintendent to the War Office published in our last issue.

In the wards, recruits rejected on account of varicocele, are being rendered efficient for service.

It has not been settled yet whether the extra accommodation in the "Park" offered by the Superintendent will be accepted by the War Office. We earnestly hope that it will be, for we know of no happier task for those who, by by force of circumstances, have had to remain here, than to give practical sympathy and help to soldiers and sailors wounded on active service.

We feel that this is the only just reward that can be given for maintaining such a high degree of efficiency throughout the early days of the present crisis.

The War Office has accepted the offer of free dental treatment for men who have been rejected on account of defective teeth. The officers in charge of recruiting stations have been instructed to send men requiring extractions and fillings; dentures will not be fitted.

Numerous old Guy's men have kindly offered their services to the Dental Department. As it is expected that the number of patients will be small at first, the services of all who have offered will not be immediately required.

Later on when work exists on a more extended scale further help will be necessary.

Happily the relapse which we reported in the last issue did not prove to be serious, and Mr. L. A. Dunn is now getting up again in the afternoon. We sincerely trust that there will be no more looking back before convalescence is completed.

The Editor will be pleased to receive old prints, manuscripts, and medical or surgical curiosities for the Guy's Museum of Antiquities, which is at present in the Library.

The arrangement and cataloguing of the specimens will be very much facilitated if those who have promised exhibits will send them as soon as possible.

Mr. C. S. L. Roberts, Assistant House-Surgeon to Mr. Hughes, has been appointed Out-Patient Officer, and Mr. H. P. Whitworth has succeeded him as Assistant House-Surgeon.

Books, etc., Received.—St. Bartholomew's Hospital Journal, Westminster Hospital Gazette, The Hospital, Clinical Journal, Nursing Times, St. George's Hospit Journal.

Replies to the Letters published in the last issue of the Gazette.

War Office,
London, S.W.
August 10th, 1914.

Sir,

I am directed to acknowledge your letter of the 8th instant, and to thank you for the offer contained therein, with regard to the speedy operation on men who are rejected for the Army on account of Varicocele.

I am to add that your offer has been communicated to the Recruiting Officers of the London District.

I am, Sir,
Your obedient Servant,
(Signed) A. B. GOSSETT, Major,
Director of Recruiting.

E. C. Perry, Esq.,
Superintendent,
Guy's Hospital,
Newcomen Street,
Borough, S.E.

War Office,
London, S.W.
August 16th, 1914.

Sir,

I am commanded by the Army Council to acknowledge the receipt of your letter dated August 8th, 1914, forwarding an offer by the Governors and Staff of Guy's Hospital, placing at the disposal of the Military Authorities certain Hospital Accommodation and Service, and to convey their warm thanks for, and to express their great appreciation of, the kind offer.

I am to state that a copy of your letter has been forwarded to the General Officer Commanding, London District, Horse Guards, S.W., in order that arrangements may be made to utilize the accommodation so kindly offered, if required.

I am, Sir,
Your obedient Servant,
(Signed) D. D. CUBITT.

The Superintendent,
Guy's Hospital,
St. Thomas's Street,
London Bridge.

Headquarters,
London District,
Horse Guards, S.W.,
August 17th, 1914.

The Superintendent,
Guy's Hospital.

Sir,

I have the honour, in acknowledging, to express my gratitude for your patriotic offer of accommodation for sick and wounded in the "Park" within your Hospital.

I have registered the offer for use in case my present arrangements, at any later date, should become unable to deal with requirements.

I have the honour to be,
Sir,
Your obedient Servant,
(Signed) B. SKINNER,
Colonel,
for Major-General,
Commanding London District.

War Office,
London, S.W.,
August 20th, 1914.

Sir,

I am directed to thank you for your very kind and patriotic offer of free dental treatment to men who have been rejected on account of the state of their teeth, but who would be rendered fit for enlistment by such treatment, which has been submitted to the War Office through the courtesy of Sir Thomas Barlow, Bart., K.C.V.O., etc.

Officers in charge of recruiting stations have been instructed to send such men to you. Extractions and fillings only will be required. Dentures should not be fitted.

When men are sent to you for treatment, they will be given a form of application bearing the signature of either the Recruiting or Medical Officer as a guarantee of their bona fides.

I am,
Sir,
Your obedient Servant,
H. BARROW,
Major,
for Director-General,
Army Medical Service.

The Dean,
Guy's Hospital Dental School,
Guy's Hospital,
London Bridge, S.E.

The War.

IT is impossible to publish a complete list of present Guy's men who have been mobilised for service. The list appended below includes some of the members of the staff and the present students. It is hoped in due course to complete this list, and also to collect the names of past Guy's men. The Editor will be pleased if readers of the GAZETTE will assist him in this difficult undertaking.

R.A.M.C. Territorial Force.

Appointed à la suite to No. 2 General Hospital, 1st London (City of London) Division.

LIEUTENANT-COLONEL.

W. Hale White.

MAJORS.

G. Newton Pitt — C. J. Symonds

L. E. Shaw

CAPTAINS.

Sir W. Arbuthnot Lane, (Bart.) — F. J. Steward

L. A. Dunn — C. H. Fagge

J. Fawcett — R. P. Rowlands

LIEUTENANTS.

C. de W. Gibb — C. E. Petley

CADETS.

J. A. M. Alcock — C. T. Helsham

W. McB. Allan — W. King Brown

R. Aspinall-Stivala — K. F. McAlpin

G. W. J. Bousfield — R. H. C. Pryn

J. F. Carter-Braine — G. A. Sims

P. G. G. Davis — W. A. Turner

St. G. D. Gray — S. Vidot

E. M. Webster

CONSULTING SURGEON TO THE ADMIRALTY.

Sir A. Fripp, K.C.V.O.

Departure of Nurses.

EARLY on Wednesday morning the first party of Guy's nurses left the Institution in St. Thomas's Street for the Front. They were Nurses Mann, Waters, Prince, Sharwood, and Owen. From here they went to Dublin, but do not seem to have remained there long.

Monday afternoon saw the second contingent leave the Hospital, consisting of Miss Kiddle (Sister Clinical), Miss Beardshaw (Sister Light), and Nurse Wilson, of the present staff; together with Miss Fraser, one time Sister Out-Patients, Miss J. Paterson, late Sister Out-Patients, Miss Hickman, late Sister Mary, and Miss Brown, late Sister Cornelius; Nurses Jickling, Shackleton, Hepburn, Stone, Ames, Bourdillon, and Druce.

A short service was held in the Chapel, an address being given by the Bishop of Southwark, Chaplain of the Hospital. After tea, which was served in the big sitting-room of the Nurses' Home, a move was made towards the Colonnade, and amid an enthusiastic gathering of students, nurses, and other members of the Hospital, they drove off to the Burlington Hotel to await further orders from the War Office. Each nurse wore a sprig of white heather, sent by Lady Goschen.

We hear that they left London on Saturday morning early for an unknown destination.

The following Guy's nurses are serving in the Military Hospitals :—

Q. A. I. M. N. S.

Edith C. Cheetham	Rose M. Rooke
Mabel Davis	Hannah Stuart
Mary E. Evans	Amy Willes
Annie B. Nunn	Maud Willes
Mary L. Potter	

Q. A. I. M. N. S. R.

Isabel Ames	Violet N. Kiddle
Mary F. Beardshaw	Margaret C. Mann
Mildred Brown	Florence A. Morgan
Mary Bourdillon	Martha Y. Owens
Constance Druce	Jeulie Paterson
Florence Finnis	Amelia Prince
Elsie G. Fraser	Eleanor H. Shackleton
Florence M. Hepburn	Hilda Sharwood
Katherine L. Hickman	Constance Strange
Jane Hills	Gladys E. Stone
Ellen M. Jickling	Gertrude F. Waters
Eleanor Jolley	Dorothy Wilson

The following nurses are also in Belgium with various parties :—

Maud A. Blenkarn	Helena McKinley
Clarrie Ward	Eunice M. Fletcher
Margaret Douglas	Frances L. Brown
Muriel Bartlett	May Nation
Florence E. Ford	Juliette Lefebvre
Florence M. Lee	Gertrude M. Keegan

If any readers know of a Guy's nurse serving at home or abroad, who is not mentioned above, Matron would be very glad to have her name and the name of the hospital or place where she is working.

Supernumerary List, R.A.M.C., for service with University of London O.T.C.

Captain, T. B. Layton.

Lieut.-Col. E. B. Dowsett, R.A.M.C.		
A. C. Clifford	... ...	3rd Cavalry Brigade
C. H. Rook	R.A.M.C. ...	... Special Reserve
A. J. Eagleton	,, ...	... ,, ,,
F. D. Annesley	,, ...	Expeditionary Force
A. H. Bevan	,, ...	——
W. R. Pryn	,, ...	——
W. K. Fry	,, ...	Expeditionary Force
A. N. Minns	,, ...	——
A. Tilbury	,, ...	——
C. Sherris	,, ...	——
A. H. Harkness, R.N.	... ...	... H.M.S. *Europa*
J. R. Barrow-Clough, R.N.	...	Armed Liner, *Coronia*
E. G. Schlesinger, R.N.	... ...	... Deal
O. Parry-Jones	... ...	... Lancashire Fusiliers
J. G. Jones, City of London Electrical Engineers T.F.		
C. Symonds	...	Motor Scout, Expeditionary Force
A. C. M. Coxon	... ...	... 5th Norfolks T.F.
H. F. T. Hogben	... ...	... 10th Middlesex T.F.
S. Keith	... ...	... 4th Queen's West Surreys
J. Conybeare	... ...	Oxfordshire Light Infantry

H. Waghorn ... ... Inns of Court O.T.C.
J. Totton ... ... ,, ,,
F. G. Berncastle ... ... ,, ,,
S. E. Johnson ... Honourable Artillery Company
G. L. Cutts ... ,, ,, ,,
D. G. Pearce ... ,, ,, ,,
E. A. Leviseur ... ... King Edward's Horse
W. J. Pretorius ... ... ,, ,, ,,
W. R. Reynell ... ... Australian Field Hospital
O. G. Morgan ... ... Private Hospital, Namur
H. Parry-Price ... Surgeon Probationer, R.N.V.R.
H. P. Bayliss ... ... R.N.V.R. Midshipman
J. L. Oates, F. W. Stiven, G. H. Howe, E. H. Bryant
J. F. Balsford, F. D. Neal (Veterinary Surgeon),
D. C. Van der Spuy, P. E. Grobbelaar, M. G. S. Hopson.

Artists' Rifles T.F.

Capt. A. R. Thompson	B. L. Laver
A. Bulleid	E. F. Llarena
C. L. Bullpitt	R. C. Matson
F. W. Crook	C. H. Medlock
— Crowe	G. B. Monk
A. K. Day-Lewis	F. J. Ordish
K. L. K. Duff	J. Palmer
D. C. Eglington	H. P. Parkes
R. J. Hodgkinson	D. A. Stanwell
J. Kyle	H. L. Thorn
C. H. Laver	G. C. Williamson

What Happened in France.

For weeks we had been hearing rumours of the approaching war. The Austrian attack on Servia, to a mere Englishman an affair as devoid of importance as a hill skirmish in India, left the French public in no doubt as to its inner significance. Long before hostilities became imminent, the press and the government were preparing the people for the conflict. From friends on the frontier towns stories were received of ammunition trains passing throughout the night and troops being mobilised in the border garrisons. But the blow itself fell with amazing suddenness.

On Friday the 31st two French friends and myself started from the little port of Douarnenez, a place of some importance in the sardine world, to sail to the Ile d'Ouessant (Ushant), noted as being the most westerly land in Europe, or at least I think so, for my geography is rather shaky.

A small and arid rock, this Ouessant, sheltering some few thousand souls, the men fishers, daring, ruthless, in the past wreckers and pirates, even to-day meriting—if the tales the folk on the mainland tell be true—the name which has passed to them from the centuries, "*pilleurs d'épaves.*" The women, beautiful and fierce-eyed creatures, are of pure Iberian stock, tillers of the soil, skilled agriculturists, masons, artisans, they fulfil with wonderful efficiency the functions of the absent men. Their national costume, seen only on great fête days, is of singular and unexpected beauty. A small cap of blue or black velvet covers their long hair, which is worn hanging free upon the shoulders, sometimes even to the waist. A bodice, cut low in the neck, shows a skin which, considering their constant exposure to sun and wind, retains a surprising freshness. The corsage itself is decorated in spiral designs of yellow and red silk, analogous to, and in one case I noted identical with, designs upon the shields and pottery of the Bronze Age found in the region of Carnac. The sleeves are of pale blue silk, and the skirt of satin of a slightly darker hue. The sabots are retained, whereas in the rest of Brittany a ceremony of any kind is an excuse for discarding the national footgear for shoes of *soi-disant* Parisian origin; but it is not the ordinary sabot of hard, unvarnished wood. Instead, a wonderful affair of leather embossed in a kind of poker work into the inevitable design of spirals and concentric circles, for, indeed, this *motif* is found in all Ouessant decoration. The houses, low, granite-built structures, retain the form of countless centuries. One feels they cannot age. A house of ten years ago is no newer and no older than one of the fifteenth century, the only perceptible difference is the freshness of the whitewash with which they are all covered. A single winding street mounts abruptly from the little harbour, joined here and there by a narrow alley, whose sides almost touch each other, a wretched *auberge*, a shop or two for groceries and fishing equipment, the post office, the gendarmerie, these complete the civilisation of Kergadon, the principal and only town of the island.

Our sail was uneventful, or at least as uneventful as a sail can be, when every moment brings a sight of ever-changing beauty. So lovely, indeed, was the sunset and so warm the night that we quite forgave the fate that held us becalmed for four hours a mile and a half from the rocks of the Pointe St. Mathieu, and the subsequent north-east breeze which necessitated several hours laborious tacking. Suffice it to say that we arrived in excellent time for Saturday's breakfast. Our reception was of that non-commital order which among peasant folk is often the precursor of an excellent understanding. A few loafers on the quay started the rumour that we were German spies, but with a command of idiomatic French which is, alas! denied to me, my companions refuted the allegation, and reflected in a manner not wholly complimentary upon the parentage and probable future of the loafers. Otherwise, the island presented what I should imagine must be its normal aspect; one thing alone struck us as singular, the Saturday steamer which brings the mails from Brest did not run.

We left on Monday morning in a drizzling rain and a sea mist with the intention of catching the rising tide into the *Goulet de Brest*. I am never at my best in the early morning, and we were all soon reduced to a state of damp wretchedness which copious draughts of a decoction known locally as "*petit Breton*" failed to alleviate. The situation, as someone remarked, "*n'était pas rigolo.*" After an indefinite period of misery the white semaphore marking the entry to the '*Rade*' appeared for a moment through the mist, and, changing our course slightly, we prepared to enter on the current. It was here that we had our first intimation of the serious turn of affairs. On the alert for the sound of breakers we caught in the distance a sound which resembled a combination of a railway goods yard in full activity and a motor cycle race at Brooklands. Rapidly the sound gained in intensity, till we seemed to be able to distinguish its component parts, the explosions of a petrol motor, the clanking, as it seemed, of chains, and the rapid rush of a boat moving at high speed. As yet we saw nothing but the grey wall of mist which swirled about us in damp clouds. The noise, now almost deafening, seemed to be heading right for us. Suddenly within fifteen yards of our bows first one periscope, then another, and behind it a third appeared. As they neared we could see the rounded dome of a conning tower and the white swish of water over their scarcely submerged decks. The submarines passed by within ten yards of us at what seemed an incredible speed, soon out of sight, leaving a wash that sent us dancing merrily for long enough.

The sound of their passage had hardly died away when we saw following in their wake the squat form of a destroyer, moving at half speed, and evidently on the lookout. In less time than it takes to tell the boat was put about, a skiff lowered and manned, and quickly rowed in our direction. A lieutenant in the bows hailed us through a megaphone, ordering us to stop, and asking our destination and nationality. Indeed, as one thinks of it, our appearance must have been enough to provoke suspicion. Three individuals armed with cameras, field glasses, luggage, and a plentiful supply of provisions, seeking to enter the chief naval port of northern France under cover of a sea mist in time of war, are enough to merit anyone's attention. Luckily both my friends had their military service papers and I a motor tryptique from the A.A. (this proved subsequently to be invaluable), so we were simply warned that to enter Brest Harbour would be to run the risk of a few rifle shots, let alone bombs, mines, and other warlike trifles. There was nothing for it but to return to Douarnenez as quickly as possible, for it was then (Monday) the second day of mobilisation.

I doubt if I shall ever forget that sail through the mist and our return to the little port that we had left so full of activity. I fancy to no Englishman can war convey so vivid and intimate sensation of personal responsibility as it does to one of the Continental nations. To us, war is so largely a matter of mere economic discomfort, of dearer sugar, and staler eggs; it is so long since England waged war for the continuance of her very being that we come to regard it simply as a time of increased tension, relieved by the pleasurable thrill of the latest from the front, and the daily lucubrations of "Our Very Special Correspondent" (carefully shepherded by a paternal government several hundred miles from the scene of operations). But with us it was different. One of my friends had lost an uncle in the war of 'seventy, the other had heard from his mother stories of the siege of Paris which she had passed through as a girl. We all of us knew veterans, and had heard from their lips of Metz, Sedan, the fall of MacMahon, the surrender of the 150,000. Every Frenchman knows, if not the actualities of war, much of its possibilities and its practice. And the result is a great sobering. Their patriotism is not of the "Lor! you should 'ave seen me on Mafeking night" order; they do not indulge in flag waving, stirring music-hall appeals with the *corps de ballet* scantily attired in Union Jacks, or invocations to the great god Jingo. For them war, this war, is a life and death conflict, the culminating effort of four decades of strenuous preparation and self-denial; it is their "*guerre de revanche.*" And so it seemed to us, as we sat there in the unbroken silence, the boat moving softly on the oily water, far from all popular enthusiasm or the courage that is bred of the crowd. We knew nothing of the conditions, only the fact. We had heard nothing of the German ultimatum to Russia or the English opposition to the Belgian violation; for aught we knew France was alone against the German millions, and if beaten we knew what mercy she must expect.

It was nearing mid-day when the sun breaking through the clouds showed to us in the distance the little town shining like a dream city through the haze. As we neared and could distinguish first the rocks of the Ile Tristan, where, so legend has it, the Knight of Brittany set forth to win his lady, then the dark woods of Ploumarch, where King March held his court until the Romans came, and last of all the port itself, as it rose, white and stately like Genoa, from the waters of the bay, we thought a little sadly that two at least of our number might never return to taste its peace again.

But in the town itself there was no time for introspection. There life seemed to resolve itself into two streams: one a joyous, rapid, noisy river, flowed over the great bridge that spans the estuary, with brave song and clattering sabots, on its way to the station. The other, a sad, black-robed company, rolled slowly back after the departure of each train, twos and threes, mothers, sisters, wives, bearing each other

what comfort they could. The hotel which when we left was full of the usual summer visitors was practically deserted. The few disconsolate wives who remained were poor company for anyone, and little remained to be done but to return to England as soon as might be.

But it was very soon apparent that to return would be no easy matter. Tales reached us of tourists stranded in all manner of out-of-the-way spots, without money, many not even speaking the language. The populace, everywhere in Brittany ignorant and suspicious to a degree, was in many places frankly hostile. Any foreigner was for them an "allebosch," and consequently a spy. In a neighbouring village a violent demonstration was held against an American family settled there for the summer, in another a French artist—a Chevalier of the Legion d'Honneur by the way—was seen sketching and hauled by excited peasants to the local gendarmerie where, of course, the charge of "spying" was dissipated amid profound apologies. Wild rumours passed the round of Germans disguised as priests and market women; one famous '*canard*' of a mysterious motor car whose occupants distributed poisoned sweets to the village children attained the eminence of a nine days' immortality.

But an exploit of my own nearly set blazing all the forest of popular imagination. Two undergrads and myself—they had been washed up from some remoter western hamlet—set forth, rather unwisely I admit, for a night's fishing far out in the bay. We departed innocently enough, but watched apparently by the remaining male population, stayed out till shortly after 3 a.m., and returned to port just after daybreak. I had a Howell's Physiology. I always take it on an expedition of this kind to ensure that I shall not be tempted to use it, and one of the others a camera. Our arrival was silent, but impressive. All the idlers on the quay stood waiting for us, and as we landed followed us in a body to our hotel. About two hours later we were roused from what we considered a well-earned sleep by an excited gendarme and an extremely sleepy Commisaire de Police. "You are spies," said the gendarme, with engaging brevity. "Messieurs," said the Commisaire, with more caution, "I regret, but I must trouble you to accompany me at once to the Mairie." And so in pyjamas and great coats we were marched off triumphantly to the Commisaire's office.

After a searching "procès verbal," during which Mr. Howell's classic work was produced as a damning piece of evidence (though I am bound to say that gentleman acquitted himself wondrous well), we were let off on condition I gave up my boat to the harbour authorities. Apparently without knowing it we had committed at least four acts for which we merited shooting at sight!

A day or two later two of us, armed with what we thought were our correct passports, left by motor for Brest to find out if any boat could be found to take us to England. If we had any doubt as to the organisation of the French defences before, we had none now. Every bridge, every level crossing, every point of strategic importance along the route was guarded by one or more pickets armed with rifles. Strange weapons, some of these, almost as rude as some of the sentries, countrymen fresh from the fields, but no easy fellows for a foe to meet if their look of dogged determination betrayed anything. At Brest we were most kindly received by the English Consul, who gave us the good news that a coal tramp, the "Mary Lindsay," was leaving Brest at dawn for Cardiff. We had soon interviewed the captain, signed on as cabin stewards at 1s. a month, and committed ourselves to all sorts of papers of whose import I haven't the least notion.

Gaily we bowled out of Brest in the motor with the intention of returning to Douarnenez to fetch our baggage. Hardly had we passed the fortifications when we heard a mighty shout; stopping quickly (the sentries in France shoot at sight), we saw what must have been about half a regiment following us at the double. Ignominiously we and the motor were hauled back as spies to the garrison, followed by an incensed mob who, either disregarding or mistaking the flags with which we had adorned the motor persisted in regarding us as (adjective) German spies. Nor was the interview with the officers in charge much more satisfactory. I was vigorously cross-questioned by a private who had, he said, spent many years in England (he had, it appeared, been a clerk in a Tyneside shipping office). Now, as anyone can imagine, a foreigner hearing the English of the industrial north and believing it to be the standard article would be rarely surprised and puzzled at the accent of the ordinary Southener. This was the plight of our Inquisitor, added to which I have a profound ignorance of the county Durham. To me Stockton-on-Tees is, and I trust will remain, a name only, so that to any questions he asked us about localities we could only reply "we didn't know." In a word, things were going very poorly indeed, when the British Consul appeared as a sort of liberating *Deux ex machina*. We were apologised to, granted fresh passports (those we had allowed us by some error only to go to Brest, but not to return), including a special permit to motor at night, which was absolutely necessary if we were to return to Douarnenez and return in time to catch the boat at dawn. Leaving my companion I set forth alone to collect our kit whilst he made final passport arrangements. That drive is like a nightmare in my memory. Loaded with several hundredweight of baggage I started for Brest at two in the morning, that much is clear, but my subsequent arrest by two drunken soldiers brandishing loaded revolvers, my trial at the dead of night by sleepy gendarmes, my

encounter with the peasants who had mounted guard over the motor evidently regarding it as the spoils of war, my rescue by more friendly gendarmes, even my arrival at Brest to find the Mary Lindsay had left half an hour previously, all are like details of some fantastic dream. The leaving of the boat, however, was true enough, and we decided the only thing possible was to motor along the coast towards St. Malo in the hopes of finding some stray cargo boat to take us over. This we did, picking up on our way an increasing flock of English in a similar plight. At Morlaix the motor gave up the ghost, but luckily enough we found a cargo boat which would take us to Havre, where we expected letters with money and where a regular service made the crossing to Southampton.

At Havre we found the town full of English troops. Suddenly from France at her wildest we felt ourselves transported to Colchester on a Sunday evening. Truly the English Tommy is a wonderful fellow. By signs, rudimentary French, and still more rudimentary pronunciation he found his way into the hearts of every good *Havrois* and *Havroises*, I think that is the right word. The enthusiasm was wonderful, thrilling, inspiring, which to me London enthusiasm never is. The sight of those men—there were sixty thousand of them, we heard, and more arriving every day—in peaceful occupation of a foreign city, fêted, acclaimed, at home—there is no other word—made one feel it was good to be an Englishman. Smitten with the war fever we applied at the staff headquarters for a job. "Anything, we don't mind," we said. Three generals we saw and officers galore (I see, on re-reading, this is poetry; it is quite unintentional), but there was nothing for us; we were the superfluous man with a vengeance. "But," said the general (his name I dare not repeat), "go home and apply at the War Office, there you'll get all you want." Full of high hope we left for home on a coal boat, for no money had come for us, escorted by two torpedo boats out of the harbour; but as I watched the last of France fade out of sight, where I had seen so much and for whose future my hopes were so high, a moment's doubt surged over me, and I asked myself whether, when next I saw that familiar coast, she would indeed be the proud France of my dreams, a nation freed for ever from the burden of the German menace, freed, too, from the yoke of a corrupt Republicanism, marching to fresh victories, though peaceful ones, under the last descendant of the Bourbon line, or whether . . but afraid to think further of that dread alternative, I retired to what sleep was possible.

And often, now, I think of an old, old man whom I hailed one evening leading his beasts from the pasture. Life had not been gentle to him, and the war had taken his two sons and five of his grandsons. "I am all alone now," he said, pointing to a stone farm house half hidden behind the trees. "*Nous sommes tout seuls maintenant, moi et la bourgeoise.*" Then with a little smile he crossed himself, "*Mais, si le bon Dieu nous donne la victoire, ce sera la paix pour toujours.*"

Let us pray that the chancelleries and the courts of Europe will not betray this old man's simple trust.

G. H. F. G.

Appointments.

PROBATIONARY DRESSERS.

A. To Full Surgeons.

Sir Arbuthnot Lane.—Messrs. T. E. Micklem, E. S. Phillips, B. Eady, D. B. Hitchings.

Mr. Dunn.—Messrs. P. D. Chapman, G. E. L. Simons, E. Foulston, M. B. M. Tweed, J. C. C. Howe.

Sir Alfred Fripp.—Messrs. N. Barlow, C. H. Kidner, C. C. Bennett, M. C. Joynt.

Mr. Steward.—Messrs. G. E. Kidman, A. Rathouse, R. B. Munday.

Those attached to full surgeons' firms will attend in the Front Surgery, Wards, and Operating Theatres at the same hours as the regular dressers on those firms, whom they will assist in every possible way.

B. To Assistant Surgeons.

A. Mr. Fagge.—Messrs. A. M. Ahmad, W. A. Hawes, T. A. Sharpe.

B. Mr. Rowlands.—Messrs. N. H. Wermig, O. Campion, R. W. Warwick.

C. Mr. Turner.—Messrs. W. A. Flynn, J. Mudge, A. H. Shelswell, C. Shelswell.

D. Mr. Hughes.—Messrs. H. V. Pritchett, H. D. Apergis, E. C. Hinde.

E. Mr. Davies-Colley.—Messrs. E. F. Deacon, K. S. Ralph, A. L. Spencer Payne.

Those attached to assistant surgeons' firms will attend as follows:—

	Surg. Out-Pat. and Strapping Room.	Operating Theatres. Afternoon.	Front Surgery. Morning.	Front Surgery. Afternoon.	Back Surgery. Morning.
Monday	C	ABD E*	B	E	A
Tuesday	E	C	A	B	C
Wednesday	A	—	D	E	B
Thursday	B	CE	E	A	D
Friday	E	AB	C	D	B
Saturday	D	—	D	C	E

* = Morning.

The following gentlemen have consented to act as Supervisors of the Probationary Dressers:—

	Back Surgery.	Front Surgery. Morning.	Front Surgery. Afternoon.
Monday	R. Curle	—	—
Tuesday	Muir-Smith	D. C. Scott	G.L.Attwater
Wednesday	Laborda	—	Stallman
Thursday	Whitworth	—	—
Friday	Galbraith	Gibb	—
Saturday	J. H. Parry	P. R. Boswell	—

Syphilitic Affections of the Upper Air Passages.

A Post Graduate Lecture by Mr. W. M. Mollison.

(*Continued from page 305.*)

Laryngeal Syphilis.—It is in the larynx that the distinction between the secondary and tertiary stages becomes so difficult; secondary manifestations may persist so long as eventually to be spoken of as tertiary. Constitutional syphilis is seen in two forms (*a*) an erythema, (*b*) as papules.

The erythematous form is not often seen as the symptoms produced by it are slight; however, one of the cases of secondary pharyngeal ulceration quoted previously showed this condition.

The case of the woman, aged 31, was an example of this so-called Lewin's erythema of the larynx due to secondary syphilis; it will be remembered that this patient had a well-marked secondary rash, ulceration about the anus and hyperæmia of the anterior pillars of the fauces; she complained of hoarseness of six weeks' duration. The larynx exhibited hyperæmia of the cords and arytenoids.

The papular form consists of what are practically mucous tubercles; they may occur on the epiglottis, in the inter-arytenoid space or on the cords, and are seen one to three months after infection or later, six to ten months after infection, and yet may not appear till years after infection. One of the cases of secondary pharyngitis showed this heaping up in the inter-arytenoid space.

Sometimes these "secondary" manifestations continue for two or three years, and then by some are spoken of as "tertiary"; these cases show themselves as relapsing laryngitis. They are often difficult to distinguish from cases of simple chronic catarrhal laryngitis; in both there is a similar heaping up of the mucous membrane between the arytenoids with reddening and slight irregularity of the cords. The following is an example of this condition:—

A man, aged 36, complained of a bad throat and hoarseness which had been coming on for two months. He had syphilis nine years ago and was treated for six or seven months. There were patches of leucoplakia on the inner aspects of the cheeks. Examination of the larynx showed great heaping up of the mucous membrane in the inter-arytenoid space, much thickening and redness of the left vocal cord and redness of the right cord; the apparent airway was very small. Wassermann's reaction was positive. The patient was given an intravenous injection of salvarsan (·4 gram.); in two or three days he was much improved, the left cord almost normal and there was less inter-arytenoid thickening. The further result is not known, as the patient ceased attendance at the Hospital.

"*Tertiary*" *syphilis* may manifest itself as localized gummata, but this is very rare, or as a diffuse gummatous infiltration. More often the late stages produce ulceration of any part of the larynx, epiglottis, or cords, and may destroy the whole larynx; it is accompanied by œdema, papillomatous outgrowths, and may eventually expose the cartilages. All these ulcerations produce great deformity of the larynx. The ulceration may start superficially in the mucous membrane, or in the submucous tissues, or in perichondrium. All these more severe forms of syphilitic laryngitis produce great heaping up not only in the inter-arytenoid space, but also deformity of the cords; these patients are apt to get dyspnœa combined with aphonia, the condition demanding at times an urgent tracheotomy, and furthermore these urgent symptoms may develop very quickly because the early symptoms are so slight.

The following case is doubtless one of syphilitic laryngitis, though Wassermann's reaction was negative:—

A man of 43 complained of a bad throat for eighteen months, progressive loss of voice, which has recently become almost complete. He had had no dyspnœa. The soft palate was destroyed by old ulceration, and was typically scarred and drawn up. The larynx was much inflamed; there was almost no visible airway, as the cords were much thickened, and the heaping up in the inter-arytenoid space was very great. The patient had had syphilis twenty years ago. He was given mercury and potassium iodide by the mouth with no appreciable result; he was then given intravenous injection of 606, also with no effect as far as physical examination showed. A physician examined the patient and reported that there were signs of phthisis at the right apex, but a further examination did not confirm this.

Clinically, this case was one of syphilis; and though the 606 produced no appreciable effect at once it may have done so later, since the patient ceased to attend at the Hospital.

The gummatous perichondritis is another form of attack in the larynx; this may arise in any part of the larynx, epiglottis, arytenoid, or thyroid cartilages; much swelling takes place

with œdema of the mucous membrane over the site of the perichondritis; this condition may pass on to necrosis of cartilage and exfoliation of pieces of cartilage, or it may be arrested and leave fibrous tissue and scarring. This scarring may lead to deformity and stenosis, or if it involve the arytenoid (as it often does) may lead to fixation of the crico-arytenoid joint. Perichondritis of the thyroid cartilage may involve the outer aspect of the ala, or the laryngeal aspect, or both. The following case illustrates these points:—

A man of 36 complained that his voice had been getting husky for twelve months, and for three months had noticed his larynx becoming more prominent. He had syphilis twelve years ago.

On examination, polypi were found in the nose; the thyroid cartilage was prominent and rounded, the usual sharp anterior angle being lost; on the right ala was a swelling apparently superficial to the cartilage but fixed to it, this was quite firm but painless. Laryngoscopic examination showed the mucous membrane to be reddened, the vocal cords thickened, their edges irregular, and much heaping up of the mucous membrane in the inter-arytenoid region, there was considerable thickening of the false cords. The result of the Wassermann's reaction was positive; the sputum was examined and no tubercle bacilli found. The patient was given an intravenous injection of salvarsan and in three days was much improved, his voice less hoarse and there was less thickening of the thyroid cartilage; in ten days' time his voice was better than it had been for twelve months.

The perichondritis more often attacks the cricoid and arytenoid; there is always much swelling of the overlying parts, and the condition is therefore serious. The results may be scarring or fixation, and this latter often affects the crico-arytenoid joint usually on one side; this results in fixation of the vocal cord and weakness of voice. The laryngoscopic appearance is characteristic. The arytenoid of the affected side is prominent and often a little swollen, and the cord is fixed and does not move out on inspiration, and on phonation when the healthy cord and arytenoid move inwards and come into apposition with the affected one, the sound arytenoid is checked absolutely by the affected one which is fixed to the cricoid cartilage; this mechanical effect is characteristic and distinguishes the condition from that of paralysis of one cord, where on phonation the sound arytenoid pushes the other one across the middle line.

Before passing to the cases of syphilis affecting the ear, it may be of interest to give figures from the present ear's Out-Patient attendances at the Hospital showing the number of cases of syphilis of the various parts of the upper respiratory tract. Of a total of 2,400 patients in the Ear and Throat Department, 56 were found to be syphilitic, and this 56 was divided as follows:

	Cases.	Acquired.	Congenital.
Nose	10	7	3
Pharynx and Mouth	20	18	2
Larynx	9	8	1
Ear	10	8	2

The *ears* are affected by syphilis either acquired or inherited. The acquired form gives rise in the early constitutional stage—secondary—to a nerve deafness which may reach a high degree but which usually clears up on the usual anti-syphilitic treatment. These cases are not to be confused with those of catarrhal deafness due to pharyngitis, rhinitis and naso-pharyngitis of secondary syphilis.

A rare condition is that of secondary ulceration in the meatus; this occurs in cases of chronic suppuration in the middle ear presumably due to the spirochætal infection via the Eustachian tube. During five years only one case has been seen in the Out-Patient Department; in that case the ulceration involved the whole of the left meatus; the condition was very painful and the discharge from the ulcer was watery; examination of the serum from the surface of the granulations by the indian ink method showed spirochæta pallida. Treatment with mercury by the mouth was instituted, and the patient recovered quickly.

Later stages of acquired constitutional syphilis cause deafness and labyrinthitis, but the cases are not easy of diagnosis; during this year many cases of nerve deafness, tinnitus, and vertigo suspected of having a syphilitic origin have been subjected to the Wassermann test, and in one case only of tinnitus was the result positive, and in one case only of vertigo was the result positive. Very different is the effect of inherited syphilis; this disease produces the most disastrous effects on the hearing; the deafness is of a very high degree and is accompanied by tinnitus and vertigo. In some cases other signs of the disease are present—such as interstitial keratitis, ulceration of the palate, bone changes, and laryngeal ulceration; in others, the deafness is the only sign of the disease.

Among 2,400 cases seen in the Ear and Throat Department this year there were eight of congenital syphilitic deafness. Excluding cases of deaf mutes the age incidence of congenital syphilis is from 12—20 usually, though it may not come on till 30 or 40. The following cases are examples of this condition.

Thomas, K., aged 23, attended in March of this year, complaining of deafness, tinnitus, and vertigo. The deafness had come on three years ago suddenly (?) in the left ear after an attack of vertigo; later the right ear became deaf. He was also almost blind from keratitis and iritis which had come on about the same time as the deafness. He must have had good sight and hearing previously as he passed into the Army at 18.

He could only hear shouting at a few inches from either ear; his bone conduction was very short and his perception of high notes bad. The Wassermann's reaction was positive.

The next case is one where the deafness was the only sign of the disease.

Cyril, H., aged 14, attended in March, 1914, complaining of deafness. An operation for removal of adenoids had been performed two years ago.

The boy was particularly bright and healthy in appearance.

He heard nothing at all in the right ear, and a whisper at one inch only in the left. Weber's test referred the fork to the left (better) ear. In the left ear the upper tone limit was greatly depressed. Wassermann's reaction was positive. The history was of interest; his mother had five other children, one son older than the patient the rest younger, and all were healthy; she had had no miscarriages, but between the birth of the eldest boy and the patient she had syphilis. On the strength of this history a Wassermann test was performed on the mother and was positive; the boy's mother was then given an injection of 606.

The prognosis for the patient is very bad, and the best advice is that lip-reading lessons should be taken at once before the hearing goes completely.

The third case is that of Herbert S., aged 19; this boy had been a patient at the Hospital on and off since the age of 4, with various manifestations of congenital syphilis; at first for laryngeal stenosis for which tracheotomy was performed, and for which the tube was still worn, later for markedly curved tibiæ and gummatous ulceration of the legs. Deafness began about the age of 14, and had become worse. On account of the gummatous ulcers he was given an injection of salvarsan, after which the deafness became worse; this raised the question as to whether the 606 had increased his previous deafness, and it is possible it had done so, though it is impossible to decide this point.

The British Pharmacopœia.

ONE of the minor results of the present war is the indefinite postponement of the issue of a new edition of the British Pharmacopœia which was to have been ready on Monday, August 10th. It was not contemplated that the new volume would be on sale on that day, but a limited number of copies were to have been supplied to medical and pharmaceutical papers for review, and persons who, for business reasons, were anxious to know what the new issue contains, were to have had the opportunity of consulting it at the offices of the General Medical Council. It was further arranged to publish the book and make it official in October, the object of this preliminary publication being to allow manufacturers and others sufficient time to prepare the medicines which would become official on the latter date.

A good deal of speculation is rife as to the cause of this postponement: it may be due to a shortage of paper but that is hardly likely and in the absence of any definite statement, which, as far as it is known to the writer, has not been made, it would seem more in accordance with possibility to assume that it is due to the undesirability of launching what will be in fact a much more stringent standard of purity for drugs, at a time when the supply is so disorganised and people are more concerned in being able to obtain drugs at all rather than on their conformity with an official standard of purity. The most intimate effect of this delay in the production of a new edition of the British Pharmacopœia, will be a corresponding delay in the appearance of the Hospital Pharmacopœia, but since in the months that are immediately in front there is small possibility of detailed work upon the latter, the result will not be very serious; at the same time it should be noted that contemplation of further delay in the revision of the Hospital Pharmacopœia which is, or should be, out of date at any time six years or so after its publication, and which is now fifteen years old, is somewhat disappointing.

A good deal of misconception exists as to the purpose of the British Pharmacopœia, and the position it occupies in medical and pharmaceutical affairs, and a glance at its history and scope may be of interest. This volume represents the chief official standard for medicines in the British Empire. It is not necessarily a legal standard in buying and selling, but whenever a prescriber orders a drug by the correct name in the Pharmacopœia, it is incumbent on the pharmacist to use the drug which fulfils the standard of that work. The Pharmacopœia contains a list of drugs in common use at the moment of its publication; hitherto the only condition governing the inclusion of any drug has been based upon the fact that it is prescribed by medical practitioners in sufficient quantity to create a steady demand. No regard is taken as to its utility or suitability. Having decided what drugs are to be included, definite tests of purity and identity are introduced which will enable the pharmacist

to determine if the articles offered to him in commerce correspond to the quality and nature of the standard set up.

The first edition of the British Pharmacopœia was published in 1864, subsequent ones appeared in 1867, 1885, and 1898 (some minor and subsidiary additions that have been published are not included in the above), so that the forthcoming issue is the fifth edition. Previous to 1864 there were three current standards for medicines in the British Isles published by the medical colleges of London, Edinburgh, and Dublin, the result of which cannot be illustrated better than by mentioning the fact that if a patient had medicine containing such an important drug as solution of morphine dispensed in London and Edinburgh, the strength in the latter case would be twice as strong as in the former. The result was that the pharmacist had not only to check the dose prescribed, but also to ascertain if the prescriber were thinking in terms of the English or the Scottish standard. The object of the first edition of the British Pharmacopœia was to sweep away this anomalous and confusing state of affairs and, as is so well expressed in the words of the preface to the 1867 edition, "to afford to members of the medical profession and those engaged in the preparation of medicines throughout the British Empire one uniform standard and guide, whereby the nature and composition of substances to be used in medicine may be ascertained and determined." The first effort to reconcile the conflicting interests of the three supplanted standards was not a success, indeed it has been asserted that a large amount of the 1864 edition was burnt, certainly a new edition was immediately called for and was published three years later.

A glance at the Pharmacopœia will show that it contains very little of interest to the medical practitioner; it is essentially a book of standards for pharmacists, and is concerned with the exact definition of those vegetable and animal products and chemical substances which are commonly prescribed, together with the "galenical" preparations made from these, and a few formulæ for mixed preparations which owe their position in it, not altogether to their merit nor to the frequency in which they are prescribed at the present day, but to the fact that they were in demand in bygone days. This is a constant source of surprise to the medical student. It seems strange to him that such combinations as, say mistura acidi composita, mistura ferri arsenicalis, which are so constantly being prescribed in practice, should not be represented in the national medicine book, whereas such seldom used combinations as mistura ammoniaci are.

By the Medical Act of 1858, the responsibility of producing the British Pharmacopœia was entrusted to the General Medical Council, which body "shall cause to be published under their direction, a book containing a list of medicines and compounds, and the manner of preparing them, together with the true weights and measures by which they are to be prepared and mixed, and containing such other matter and things relating thereto as the General Council shall think fit, to be called the British Pharmacopœia; and the General Council shall cause to be altered, amended, and republished, such Pharmacopœia as often as they shall deem it necessary."

Unfortunately, when this act was passed, it was not anticipated that the very advance in medical education which it is one of the privileges of the General Medical Council to foster, renders that body increasingly unfit for the task of producing the Pharmacopœia. Although fifty years ago it was probably not difficult to find members of that body possessing sufficient knowledge of the art of pharmacy and of the allied sciences, botany, and chemistry, upon which it is based, to produce a Pharmacopœia worthy of the name; yet at the present time, owing to the natural divergence of all branches of science, and particularly of the specialisation in medicine, it must be increasingly difficult, and almost impossible to find medical men equal to such a task.

Such a state of affairs could not have been foreseen; but in respect of the revision of the Pharmacopœia being exclusively in the hands of the medical profession, and in the absence of any direct representation of pharmaceutical knowledge, the British Pharmacopœia is unique. It is true there is a Committee of Reference in Pharmacy, but this body has no responsibility in the matter, and occupies a subsidiary position, and it is not surprising that its members particularly, and the pharmaceutical calling generally, are very dissatisfied with the undignified rôle that is thrust upon them, and steps have already been taken to put an end to this state of affairs. Although this is not the time nor place to enter fully into this matter, it would seem that a frank recognition of the necessity of joint work and an appropriate distribution of the proceeds from the sale of the Pharmacopœia for the encouragement of research in both branches is not unreasonable.

H. FINNEMORE.

Papers by Guy's Men.

E. Graham Little: Some Common Errors of Diagnosis in Skin Diseases.—*Clinical Journal*, August 12th, 1914.

L. C. Panting: Cystic Hygroma. — *Practitioner*, August, 1914.

T. G. Stevens: Operative Treatment of Uterine Pregnancy.—*Clinical Journal*, August 5th, 1914.

F. Taylor: Rigor.—*Practitioner*, August, 1914.

A. H. Tubby: Orthopædic Surgery. — *Practitioner* 1914.

Change of Address.

Staff-Surg. H. R. H. Denny, R.N., from H.M.S. *Amphion* to H.M.S. *Faulkner*, 3rd Destroyer Flotilla, c/o G.P.O.

Some Further Therapeutic Points.

Being an Address by HERBERT FRENCH, M.A., M.D. (Oxon.); F.R.C.P. (Lond.); Physician to Guy's Hospital.

Mr. PRESIDENT AND GENTLEMEN,—I thank you for the honour you have done me in inviting me to make these remarks to you this evening, and I only hope that you will not find what I have to say too trivial or too familiar to be of use. I propose to touch on a number of separate practical points, none of which are original. You must pardon me if you know of them all already, but I have found that even when things are known about they are not always made use of as often as they might be, and that must be my excuse for bringing them before you to-day. The reason for using the word "further" in the title of this address is that I have already discussed a number of similar points elsewhere, and although I should have liked to have mentioned some of those again to-night, I shall refrain from doing so because they have been published in the *Medical Press and Circular* for May and December, 1912.

The first point that I should like to bring to your notice is

The Value of Horse Serum and Ox Blood in the Treatment of Resistant Simple Anæmia.

Of course, the great majority of cases of anæmia are remedied easily by the ordinary simple treatment of rest in bed and the administration of one or other of the many preparations of iron with or without arsenic, steps being taken at the same time to insure a regular action of the bowels. Six weeks in bed under this treatment will generally cure almost any case of chlorosis, however severe the latter may be to start with, especially if the room in which the patient is being nursed is a sunny one; but now and again one meets with a patient whose anæmia proves so refractory to treatment that none of the ordinary things seem to do any good at all. Rare though these cases may be, all of us meet with them from time to time, and the question arises as to what further kinds of treatment can be adopted. Both horse serum and ox blood may then be used, and sometimes with extraordinary benefit. The patient is generally an unmarried woman of the better-to-do classes, and she may have been to see all kinds of doctors and may have visited various spas noted for the treatment of anæmia. In one such case recently, for example, the lady was 33 years of age, and for over ten years she had been so anæmic that she had been unable to take any active part in life or in the doings of her brothers and sisters, and she had become quite hopeless of ever being cured. Her hæmoglobin measured only 35 per cent. of normal, there was no organic disease of any of the viscera, and yet all attempts to cure her anæmia had failed hitherto. Within two months of treatment by horse serum and ox blood her hæmoglobin had risen to 95 per cent. of normal, her red corpuscles were over 5,000,000 per cubic millimeter, and she felt perfectly well. She may, of course, relapse as so many of these patients do, but that does not altogether detract from the value of the treatment. It is carried out as follows: The patient is put to bed in a sunny, airy room with wide open windows, and upon a full ordinary diet including particularly the natural gravies from roasted meats. For each of eight successive days she is given a subcutaneous injection of 10 c.c. normal horse serum, preferably into the deep subcutaneous tissues of the abdominal wall. The serum is obtainable sterile and ready for injection in glass phials like those in which ordinary antitoxic serum is supplied. It is sometimes possible to give a ninth or even a tenth injection, but the phenomena of anaphylaxis and severe serum reaction generally prevent more than eight doses being given, and one is, in any case, obliged to stop by the tenth day because beyond this point the giving of more serum is actually dangerous on account of anaphylaxis. The patient should be warned previous to the beginning of the treatment that she will have considerable reaction with pyrexia up to perhaps 102° F. or even higher, starting, as a rule, about the eighth or ninth day and persisting more or less, but not getting continuously worse, up to the seventeenth or eighteenth day if eight injections are given, or to the nineteenth or twentieth day if nine or ten injections are given. Until this is past the patient should remain entirely in bed. During this pyrexial period she will feel more or less ill in herself and will very probably suffer from urticaria, which is sometimes mainly local to the site of injection, but more often occurs all over the body. It has been recommended that calcium lactate should be given in 10 gr. doses three times a day with the idea of minimising these serum phenomena, but in practice this drug is disap-

pointing in this connection; 10 gr. doses of aspirin given once, twice, or three times a day often alleviate the itching of the skin and the headache. Locally one may dab on a lotion consisting of one part of rectified spirit in three parts of water, to each pint of which are added two tablespoonfuls of glycerine and a teaspoonful of bicarbonate of soda, or some weak caustic soda.

When the reaction is over, that is to say, about the twentieth day from the beginning of the treatment, one can begin giving fresh defibrinated ox blood per rectum. If one could continue indefinitely with the horse serum, one would do so, but on account of the anaphylaxis a considerable interval must elapse before further doses of it can be given with any safety. The defibrinated ox blood, on the other hand, can be given without any danger and continued indefinitely. It is obtainable by arrangement with any butcher who kills his own animals; he whips the blood to defibrinate it, and pours it into bottles that have been sterilised by boiling, and places these on ice; the blood should be kept on ice until it is used. If fresh blood can be obtained each day, this is best of all, but, as a rule, the butcher does not kill every day, and it may be necessary to arrange for a three days' supply at a time. A suitable dose is five ounces, and it is given like an ordinary nutrient enema with rubber tube and glass funnel. The bowels having been opened well in the morning the nurse inserts the small rubber rectal tube about six inches into the rectum and the blood is allowed to run in through a suitable funnel held two or three feet above the patient. To insure the blood being retained it should not be allowed to run in too quickly. The number of days this treatment should be continued depends upon the progress of the case, but, roughly speaking, it may be continued for four weeks and then stopped. The patient should remain recumbent for two hours at least after the injection, but by this time her progress will generally have been such that she is able to get up in the afternoon, and during the summertime she may lie on a couch in the garden as much in the sunshine as possible, or even go for a drive. She should not, however, do any walking yet. In a very severe case the total length of treatment occupies from six to eight weeks, by which time the patient is generally able to begin walking again, and very soon afterwards she can return to ordinary life. It is as well to continue the administration of iron with or without arsenic in some form or another during the whole period, and a very efficient and convenient form of giving these two drugs is as the alginate of iron and as solid arsenious oxide, ten grains of the former and 1/60 gr. of the latter in a cachet, one such cachet being given three times a day if they are borne well. Pain in the back is sometimes severe when iron is given, but this symptom is less troublesome with the alginate than with almost any other form. Towards the end of the treatment the patient often complains of a stuffy, full feeling in the head; when this is very troublesome the amount of alginate of iron may be reduced and presently the drug omitted altogether. The fulness in the head is in some way due one supposes to the unwonted activity of the blood-forming red marrow in the cranial bones.

Precisely similar treatment may be employed to accelerate recovery after severe hæmorrhage in association with fibroids of the uterus, duodenal or gastric ulcer, or hæmoptysis. If, in these circumstances, it is felt that the patient is too ill to bear the serum reaction, only one or two doses of horse serum may be given and then the ox blood per rectum. The ox blood generally causes no untoward effects at all, and in this respect is quite different from the horse serum given subcutaneously. It is hardly necessary to add that when the monthly period occurs during the course of the treatment the injection of ox blood per rectum will be omitted temporarily.

The next point I should like to refer to is—

The value of brandy packs to the chest in cases of severe cough preventing sleep.

These are particularly valuable in the case of children who, when suffering from bronchitis, or from whooping-cough, or sometimes from intrathoracic irritation from enlarged thoracic glands, perhaps tuberculous, are sometimes kept awake to the point of absolute exhaustion by incessant coughing, generally without expectoration to relieve it. If these persistent coughing attacks are controlled by medicines, well and good. Sometimes, however, they go on and on in spite of all the ordinary drugs, and one wishes one could do anything to relieve the child, who is getting thoroughly exhausted. The brandy pack will often prove invaluable under such circumstances. It is a very old remedy, and probably all of you are familiar with it and use it, but in case not I should like to call attention to it. One needs a large single piece of flannel long enough to go one and a half times round the chest and wide enough to

extend from the neck above to the umbilicus below. About four inches from the top of this one cuts two round holes, one for each arm; and one needs a large piece of gutta-percha tissue or jaconet of sufficient size to cover the whole of the flannel when it is in position, also with two arm-holes cut in suitable positions. One mixes three ounces of brandy with six ounces of cold water in a basin and steeps the large flannel in this until it is thoroughly wet all through; one just squeezes it enough to leave it quite wet, but not actually dripping. The child's chest is stripped, the flannel is held out straight, the arms put through the holes cut for them, and the free ends of the flannel crossed smoothly over the back; the jaconet is then applied over the flannel in the same way, the whole being kept on by quickly winding a broad bandage loosely all round the chest and over the shoulders. Some prefer to use the brandy and water hot, but most relief is obtained by using it tepid or cold, and doing so is no danger to the child, for very quickly the heat of the body, especially as the result of the increased amount of blood which the brandy pack brings to the surface of the chest, makes the application steaming hot, and in half an hour or less the child very often falls into a peaceful slumber, which may last for several hours without any coughing at all. Precisely similar treatment may be employed in some cases in adults, but the most striking benefit is obtained in children, especially between the years of five and ten. Again and again one has seen refreshing sleep ensue when, up to the time of using the brandy pack, all other measures have failed.

The next point I should like to bring before your notice is—

The value of biborate of soda in the treatment of resistant cases of epilepsy (grand mal).

This is an old remedy for the purpose but it is not employed so frequently as it might be.

In ordinary cases of epilepsy, of course, small or medium doses of bromide of potassium do all that is required, and one needs no other drug in the treatment of these cases. Sometimes, however, one meets with patients whose fits are very imperfectly controlled by bromides. If they have no medicines at all they may be having fifteen or twenty attacks of epilepsy a week; when one gives increasing doses of bromide of potassium with or without arsenic and other familiar remedies until they are taking two, three, or even more drachms of the bromide a day the fits may be reduced to three or four a week, and yet do what one will the attacks may persist to this modified extent. If one now prescribes ten grains of biborate of soda in cachet form, or as the plain powder washed down with some water or some milk, one will sometimes find that for every ten fits the patient had previously on bromide treatment alone he may now have only one or even less. In some cases, indeed, the fits may be stopped altogether, or they may occur only at long intervals, very much longer than was the case when the bromide treatment alone was given. Moreover, it is frequently possible to reduce the amount of bromide at the same time; for instance, whereas it might have been necessary to give forty grains three times a day previously, one may get fewer fits although one reduces the bromide of potassium to a single dose of twenty grains given in a tumblerful of water in the morning, if one also gives ten grains of biborate of soda three times during the day. The advantage of this to the patient is very great because the biborate of soda is not depressing and very big doses of bromide of potassium almost always are. One objection to the drug is its nasty taste, but the patients are only too keen to take any remedy that will help them to lose their fits, and most of them take the crude drug as it is without any difficulty at all. It is less nasty, perhaps, when given as the plain powder than it is when an attempt is made to prepare it in mixture form. Two recent hospital out-patients have improved so much under the biborate treatment that whereas upon bromides they could get no employment at all they are now back at permanent work.

The next point that I wish to draw attention to is—

The value of venesection in certain chronic conditions especially arterio-sclerosis and polycythæmia.

After a period in the early part of last century when venesection was performed indiscriminately for almost any malady, and was therefore much abused, this therapeutic measure fell into disrepute so that it was seldom resorted to at all; there has now, however, been a reaction in favour of it under certain circumstances, and most physicians do not hesitate to bleed patients suffering from certain acute maladies, especially uræmia, lobar pneumonia in a plethoric subject, and acute heart failure from valvular disease or myocardial degeneration. It is, however, by no means only in acute conditions of this kind that venesection can do good, and the relief afforded to many persons suffering from arterio-sclerosis with greatly

raised blood pressure by periodic venesection, say at intervals of a month or six weeks to two months is sometimes remarkable. One of the objections to venesection in the past has been that it then meant incising the skin and thus producing a wound which might become septic, and in any case meant a dressing; now, however, by means of short hollow needles such as these which I show you here, and which are made for me by Messrs. Down Bros., it is quite a simple thing to venesect a person to fifteen or twenty ounces or even more in one's consulting room, the patient being able to go straight away to his ordinary duties after the little operation without any dressing upon the arm at all. The broad rubber bag that one uses in connection with a sphygmomanometer is of great assistance in this connection; applying it to the upper arm one pumps air into it until one just obliterates the radial pulse; having found the maximum systolic pressure in this way, one now lets a little of the air out of the bag until the pulse has returned, and in this way one has a very simple tourniquet in which one can regulate the pressure to a nicety, and one does not hurt the upper arm in the way that the narrower rubber tourniquet often used to. Moreover, the broad band of pressure round the upper arm seems to impede the transmission of painful impulses from the nerves of the forearm to the brain, so that the patient feels less than one might expect when one inserts even a big needle into the distended veins in front of the elbow. It is necessary to have a wide short needle, for otherwise if one uses a longer narrower needle such as one through which one gives a dose of antitoxic serum, after the first two or three ounces of blood have run out the flow gets gradually slower and finally ceases from clotting in the narrow tube. It is an additional advantage to have a rubber attachment such as the one I show you here; by means of it one can direct the blood into the measuring glass or other receiver more conveniently than one can straight from the metal needle itself. It takes from ten to twenty minutes to let out twenty ounces of blood from a vein in this way in an ordinary case of arterio-sclerosis. On releasing the air from the pressure-bag the bleeding stops at once; after removing the needle a few drops may escape, but if the arm is now held vertical for a minute or two it is found that no further bleeding occurs and the puncture hole needs no dressing whatever, though it may be wise to powder a little boric acid over it. The patient goes to his ordinary work directly afterwards without feeling any ill-effects; indeed many ask to have it repeated periodically because they feel so much better for some time after it.

How the venesection acts it is not easy to say. It certainly does not do so by reducing the blood pressure, for the latter is affected by it very little if at all; one imagines, however, that when a bulk of blood is thus removed from the vessels it is made good by absorption of other fluid from the tissue spaces; the latter in their turn require a fresh supply from wherever they ordinarily get it, and so there is an all-round renovation as it were for the time being. At any rate there can be no doubt as to the beneficial results in actual practice if cases are properly selected. One sees the same benefits come about spontaneously from a severe epistaxis sometimes. Venesection with a hollow needle, with a sphygmomanometer bag for tourniquet, is so easy that I should like to see it used more widely, not in acute conditions only but also in selected chronic cases of arterio-sclerosis, polycythæmia, plethora and high blood pressure.

Next let me refer to—

The value of emetine hydrobromide in the treatment of amœbic dysentery and of amœbic abscess of the liver.

It is to Major Rogers, of the Indian Medical Service, that we owe the discovery of the fact that the most important ingredient of ipecacuanha in the treatment of dysentery is precisely that which in the purified form of the drug is thrown away because it produces so much vomiting. It is the emetine of ipecacuanha which is the essential factor in the cure of dysentery by this drug, and Major Rogers made the still more important discovery that the hydrobromide and the hydrochloride salts of emetine can be given hypodermically with rapidly curative results both as regards the dysentery itself and its complications; whilst when so given it does not cause the vomiting, etc., which crude ipecacuanha is so apt to produce. The drug is now obtainable in the form of little glass bulbs, each containing $\frac{1}{2}$-grain of emetine hydrobromide in sterile solution ready for injection, whilst the hydrochloride is supplied in the form of tablets which can be dissolved in sterile water and thus injected. One does not, of course, meet with amœbic dysentery or any of its complications every day in this country, but in almost every practice a case of the kind turns up, the disease, contracted in the tropics, either having persisted until the patient returns home, or else recurring in this country after an interval

of apparent cure. In several hospital cases of late and in one or two others the curative effects of emetine hydrobromide have been little short of marvellous. In one such patient there had been continuous pyrexia for over two months; the bowels were moved four or five times a day, sometimes with blood, sometimes without; there was pain and tenderness over the liver, and there was the dome-shaped dulness at the right base, together with a friction rub here, and other signs pointing to the existence of hepatic abscess. Quinine and other remedies had been tried without any benefit at all: emetine hydrobromide was given hypodermically by Dr. Lacey, of Woolwich, and within a fortnight the temperature had come down to normal; the hepatic signs had almost disappeared, the diarrhœa had ceased, and the patient made a rapid and complete recovery without any operation being done. One can give ½-grain of the emetine hydrobromide three times a day, but in many cases a single dose per diem is sufficient; at any rate, it is wise to start with one dose a day, increasing this if circumstances indicate the need to do so; it does not seem to produce any untoward effects.

It is particularly in the amœbic form of dysentery and in association with the amœbic abscesses in the liver that may follow such dysentery that the emetine hydrobromide does most good, but it has also been tried in the bacillary form of the disease, and one would like to test its effects in those very difficult cases which occur in this country—allied to dysentery but due to an organism as yet unidentified—namely, English ulcerative colitis. I have not yet had an opportunity of trying it in the latter to any great extent, but perhaps some of you may be able to do so.

The value of emetine injections in the treatment of continued severe hæmoptysis is another point worthy of mention, though I do not propose to discuss it in detail to-night.

(To be continued.)

Appointments.

Civil.

E. G. Schlesinger, reappointed to a B.M.A., Research Scholarship, for one year from October 1st, 1914.

C. H. Mills, M.R.C.S., L.R.C.P., has been appointed Honorary Assistant Surgeon to St. Paul's Hospital for Skin and Genito-Urinary Diseases, Red Lion Square, W.C.

F. J. Tipper, to be Hon. Dental Surgeon to the Royal Portsmouth, Portsea, and Gosport Hospital.

Military.

Stanley Wickenden, M.R.C.S., L.R.C.P. Lond., has been appointed Lieutenant in the Royal Army Medical Corps (Special Reserve).

Royal Army Medical Corps.

Captain P. C. Field is seconded for service with the Egyptian Army (dated July 1st, 1914).

To be Captain (dated July 27th, 1914) Lieut. D. Reynolds.

Major L. Humphry has been placed under orders for service abroad.

Capt. R. T. Collins has been placed under orders for service abroad.

Capt. D. P. Watson has been appointed Clinical Pathologist at the Curragh.

Territorial Force, R.A.M.C.

Supernumerary for service with the Officers' Training Corps: Lieut. T. B. Layton, serving with the University of London contingent, Senior Division, Officers' Training Corps, to be Captain (dated July 3rd, 1914).

Royal Navy Medical Service.

Staff-Surgeon A. R. Thomas to the *Pembroke*, additional, for disposal.

Indian Medical Service.

The services of Captain P. K. Tarapore, Superintendent, Central Gaol, Mandalay, are placed permanently at the disposal of the Burma Government for employment in the Gaol Department.

Army Medical Service.

CHANGES OF STATION.

Major J. C. B. Statham, from London District to West Africa.

Captain D. R. Watson, to the Curragh.

Captain C. H. Denyer, from Agra to Parkhurst.

Captain W. H. S. Burney, from Ferozepore to Solon.

Colonial Medical Service.

Dr. A. L. Fitzmaurice has been selected for appointment as a Medical Officer, Somaliland.

Sir Gilbert Blane Naval Medal.

The Royal Colleges of Physicians and Surgeons have awarded the Sir Gilbert Blane Naval Medal to Surgeon G. F. Symns, R.N., who obtained the highest aggregate marks at the examination for promotion to the rank of staff-surgeon at the Medical School of the Royal Naval College, Greenwich.

Pass List.

University of Durham.

The degree of M.B., B.S., was conferred on—

H. H. Elliot. H. V. Leigh.

SECOND EXAMINATION FOR DEGREE OF M.B.

Anatomy and Physiology.

M. C. Joynt. H. I. Sterne-Howitt.

Conjoint Examination.

PRELIMINARY SCIENCE L.D.S.

First Examination.

†W. A. Cooper. *†A. Maher.
*†L. D. Crabb. *†E. A. P. Parker.
*†W. Dingley. †E. F. Shaw.
*†A. Gordon. *†H. M. Smith.
†J. Herbert. *Van der Spuy.
*†J. C. Johnson. †P. J. S. de Wet.
*†R. V. Kingham. *†L. G. Whelpton.

* Chemistry. † Physics.

FIRST EXAMINATION.

Chemistry, Physics, Elementary Biology, and Practical Pharmacy.

†‡F. J. Biddle. *†C. Moffatt.
‡E. S. Goodwin. *††‡R. B. Munday.
‡G. R. Hubbard. *A. R. Neckles.
‡E. Kopelowitz. †A. A. Osman.
‡B. Laver. ‡R. E. Williams.
‡G. Meadows. †S. Woolf.

* Chemistry. † Physics. ‡ Elementary Biology.

FINAL EXAMINATION.

Medicine, Surgery and Midwifery.

*A. L. Anthony. *S. A. Liebson,
*A. H. Harkness. *C. E. Petley.

Medicine and Surgery.

F. H. Dodd. R. W. P. Jackson.

Surgery and Midwifery.

B. Burnside. L. R. Pickett.
*A. K. Selim.

Medicine and Midwifery.

P. R. Chevreau. *D. M. MacManus.
C. de W. Gibb. C. R. Smith.
J. A. Stephenson.

Medicine only.

A. Abd-el-Al. A. N. Minns.
*H. H. Elliott. *F. G. L. Scott.
C. G. McClymont. *P. D. Scott.
D. C. Scott.

Surgery only.

*F. A. Beattie. G. W. King.
*W. D. Galloway. R. C. Ozanne.
E. C. W. Starling.

Midwifery only.

G. L. Attwater. H. L. Messenger.
J. S. Cocks. W. H. Nicholls.
R. J. Hearn. F. W. Sheldon.
L. Horsley. *F. L. Spalding.
*C. Lambrinudi. *T. A. Townsend.
W. A. Young.

* Denotes completion of examination.

Royal College of Physicians.

At a meeting of comitia, H. W. Barber, M.B. Cantab. was admitted a member of the College.

Indian Medical Service.

The following candidates were successful:—

Philip Savage - 3071 marks.
S. B. Venugopal - 2697 „

London School of Tropical Medicine.

The following candidate was successful:—

B. H. Wedd, M.D.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES, July, 1914.

R. V. Cookes. A. E. Sawday.
W. H. Grace. S. A. Sharpe.
St. Geo. B. D. Gray. A. H. Shelswell.
E. H. L. Lectezio. W. H. Simmons.
G. F. Peters. W. Skelly.
R. S. Ralph. R. W. Warrick.
E. R. Webb.

SECOND EXAMINATION FOR MEDICAL DEGREES.—July, 1914.

Part I.—Organic and Applied Chemistry.

C. H. Atkinson. C. G. Haynes.
W. A. Flynn. N. Kamchorn.
J. C. Gie. B. G. Marshall.
W. A. Hawes. A. Rathouse.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Practice of Medicine. By Frederick Taylor. (J. & H. Churchill.) Price, 18s.

This, the tenth edition of Dr. Taylor's excellent text book, is too well known to need any introduction to students and practitioners.

Besides a general and thorough revision, the present edition shews changes in the arrangement of some of the subjects. Thus, the infectious diseases are somewhat differently grouped; a section on abnormalities of cardiac action, including many of the conditions formerly called functional disorders, precedes the account of diseases of the heart, and the diseases of the ductless glands, having internal secretions, are treated in a separate section, apart from the diseases of the blood and the blood-forming organs.

Further, a group of disorders of bones and joints has been separated from disorders of nutrition and metabolism, which last includes gout, diabetes, and some others. Acute infections, anterior poliomyelitis, finds a place among infectious diseases, chorea is transferred to diseases of brain, and diabetes insipidus to functional diseases of central nervous system.

The section on diseases of the heart has been thoroughly revised and brought up to date in touch with recent work: the chapter on abnormalities of cardiac action having short articles on heart block, partial and complete, premature systoles, with tachycardia and bradycardia, to which several tracings of venous pulses and electro-cardiograms add considerable interest.

Several new subjects are introduced, including coarctation of the aorta, obesity, diseases of pineal and pituitary glands, and Friedländer pneumonia, where more mention of the so-called mixed infection pneumonia would have been of interest, and of its increasing incidence at the present day with pneumococcal septicæmia.

The illustrations are still further increased, together with some new skiagrams of chest, heart, and abdomen, presenting examples of Dr. Jordan's excellent work.

In the diseases of the intestine, the article on constipation is followed by a concise account of the present-day vexed question of alimentary toxæmia, in which connection three factors are mentioned—first, the occurrence of new poisons or toxins; secondly, the breaking down of the mechanisms by which normal poisons in the alimentary canal or elsewhere are prevented from reaching the blood; thirdly, fæcal retention and chronic constipation, with which Sir Arbuthnot Lane's views are outlined.

We would congratulate Dr. Taylor on this, the tenth edition of his world-famous text-book, and feel sure that it will maintain its present position as one of the best, if not the best, students' text-book of medicine.

Manual for Women's Voluntary Aid Detachments. By P. C. Gabbett, M.R.C.S. (Bristol; John Wright & Son, Ltd. London: Simpkin, Marshall & Co., Ltd.) Price 1s.

A most useful and comprehensive Manual which should be in the hands of every Aid Detachment.

Literary Intelligence.

The Year Book of Radiology for 1915 is announced by Messrs. Longmans & Co., as in preparation, edited by Robert Knox, M.D., and James H. Gardiner, F.C.S. The object of the work is to give an account of the more recent advances in our knowledge of radium, X-rays, and the allied phenomena, both from the medical and physical point of view. The volume will comprise a series of authoritative articles by specialists working in radiology, and a directory of qualified medical men practising in radiography, X-rays, radium, and electrotherapeutics, both at home and abroad; also a list of hospitals and institutions where such treatment is carried out. Notices of new books and apparatus, legal information, physical data, hints for the laboratory, and all matters connected with the practice will also be included. The volume is intended to form, as far as possible, a bond of union for those engaged in the practical applications of the various forms of radiation, both at home and abroad.

Birth.

JARVIE.—On August 17th, at 4, The Birklands, Torquay, S. Devon, the wife of J. M. Jarvie, M.A., M.B., B.C., of a son.

Marriages.

CLARKE—HASLUCK.—On August 15th, 1914, at St. Fimborrus' Church, Fowey, Cornwall, Kenneth Bleckly Clarke, M.R.C.S., L.R.C.P., youngest son of Sir William and Lady Clarke, of Chatteris, Cambridge, to Dorothy Milborough, elder daughter of the Rev. E. E. and Mrs. Hasluck, of Sixpeny Handley, Dorset.

REYNOLDS—YOXALL.—On July 29th, at St. Margaret's Church, Ilkley, Yorkshire, Augustus John Reynolds to Gladys May, only daughter of Martin Yoxall, Esq., Ilkley.

WARNER—TAYLOR.—On July 25th, at Southwark Cathedral, Harold Percy Warner, M.B., B.S., to Kathleen Rose, eldest daughter of J. P. Taylor, of Old Charlton, Kent.

Death.

PURDOM.—On August 12, 1914, Malcolm Neish, age 2, second son of Dr. Percy Purdom, of Clevedon, Grove Road, Sutton, Surrey.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE learn that the House-Committee do not see their way to reserve any wards or beds exclusively for the use of sick and wounded soldiers. This decision will greviously disappoint many of us, both past and present, who would like to feel that Guy's was actively taking care of successive relays of the sick and wounded from the front.

Personally we are very sorry that Guy's is to be deprived of this privilege, not because we think that there has been any falling away from the great traditions and ideals of the Hospital, but because the care of the wounded appeals to the imagination, and is more exciting and more tangible evidence that we are doing our share than is the ordinary routine of the Hospital. At the same time, one must regretfully agree that the authorities have reason on their side in believing that the Hospital will be doing a greater service to the State in devoting all its energies to the care of the civil population. It must be remembered that already the number of beds available for the sick poor in London has been reduced by several hundreds, that there is a very strong probability of increased sickness during the winter as a result of distress, and that therefore our beds will be in greater demand than before. Our own district of Bermondsey will very probably feel the effects of want and unemployment before very long. The increased price of sugar is bound to curtail the output of the jam-making industry which employs large numbers of women who even in the best of times seem to live from hand to mouth.

Although they have given no beds to the Army authorities, the House-Committee have offered to do all they can to provide any special medical, surgical, or dental treatment which is not otherwise available. They have also renewed their offer of accommodation in the "Park" for wounded, but the War Office have not accepted this offer as they have already more than sufficient beds for the present needs.

IN the last issue of the GAZETTE we commented on the *esprit de corps* of the Residents which prevented them from following their natural impulses and rushing off to offer their services to the War Office without a thought for their duties to the Hospital. We are, therefore, very glad to hear that the Governors fully appreciate their self-sacrifice. At a recent meeting of the House-Committee the Chairman expressed to the men personally the Committee's great gratification at this signal mark of their loyalty to their work in very difficult circumstances. As most of our readers are well aware the temptation to throw up everything and join the Army or Navy is very strong, even in those who have family and other ties, and it reflects the more credit, therefore, on the Residents, most of whom have no special reasons for not serving, that they stuck to their posts. Most of those who finish their appointments in October have already made arrangements to join one of the services as soon as they are free.

The Chairman of the House-Committee also thanked the Matron on behalf of the nurses, and the Superintendent on behalf of his staff, for their loyalty.

WE publish in this GAZETTE a list of Guy's men who have been recently gazetted to commissions in the Army and Navy. This list only includes those who have joined as Surgeons, and we have made no attempt to compile a list of those who have joined either the Regular or Territorial Forces in any other capacity. The GAZETTE is anxious to prepare a complete list of *all* Guy's men who are serving in any capacity with the Forces, either at home or abroad, and the work would be much simplified and more accurate if every man who has been called up would either send a post card with particulars to the GAZETTE, or give his name to the Wills Librarian.

In addition to the names on the list in this number, there are 50 Guy's men on the regular establishment of the R.A.M.C., 40 in the Navy, and 31 in the I.M.S. There are also numerous men who have already offered their services and are waiting to be gazetted.

THE names of three Guy's men have already appeared in the lists of casualties. Captain M. Leckie, R.A.M.C., is reported as wounded, and Captain G. H. Rees and Lieut. M. K. Nelson, R.A.M.C. as missing.

As there seems to be some uncertainty in various quarters as to the intentions of the Medical School we may say that the Winter Session will open as usual on October 1st, when all the lectures and demonstrations will be given as in ordinary years. As yet no changes of any importance have been made, and it is the intention of the authorities to make as few alterations as possible. The special courses for the F.R.C.S. have already begun.

WE greatly regret to have to record the resignation of Mr. William Wale, F.R.Hist.Soc., the Wills Librarian. Mr. Wale had only been Librarian since July, 1911, when he succeeded the late Mr. P. Mills. Before coming to Guy's he had been Assistant Librarian at the Royal Society of Medicine. Although only Librarian for three years, Mr. Wale with characteristic energy thoroughly reorganised and recatalogued the books. He improved the efficiency of the Library several hundred per cent., and displayed himself an astonishing knowledge both of the names and contents of all his books. During his tenure of office Mr. Wale thoroughly identified himself with the Hospital, and compiled, in addition to a very useful list of books by Guy's men in the Wills Library, complete bibliographies of the publications of Sir Samuel Wilks, Mr. Targett, and Sir Arbuthnot Lane. He leaves with the good wishes and regrets of all who had occasion to use the Library.

He is succeeded by Mr. J. H. E. Winston, recently Chief Assistant Librarian at the Royal Society of Medicine.

THE Librarian would be glad if the borrowers would return at once any volumes which they are no longer using or which they have already held for some considerable time. The continued absence of several of them is causing annoyance and inconvenience to other men. The carelessness of many men in this matter of borrowed books is nothing short of scandalous. They take out some work which is in constant demand read parts of it and then throw it aside without a thought for the convenience of the next prospective borrower. Apparently the habit is growing, as this is the second appeal we have made on behalf of the Librarian during the last few days.

We hope that this second notice will be more effective, as the demands on the library will naturally be more frequent during the coming session than in the summer months.

Papers by Guy's Men.

Norman Flower: Intraperitoneal Rupture of the Bladder.—*British Medical Journal*, August 29th, 1914.

Sir George Savage: The Feeble-minded and their Cure.—*Clinical Journal*, September 2nd, 1914.

Through France in Time of War.

"Russia has interfered between Austria and Servia; then that means a European blaze."

On July 30th we were having dinner in a little inn in the Val de Rhême, not far from Aosta, when one of the other visitors made this remark. As he was an Italian, and we could not speak his language, we were unable to pursue the subject, and, indeed, we were more occupied with our plans for the next day than with a vague possibility of a great war. We had seen no newspapers for nearly a week and knew nothing of the efforts being made to preserve, on the one hand—and to destroy on the other—the peace of the world.

The next two days we spent in crossing a snowy pass and then walking up to Courmayun, which lies at the foot of the Italian slopes of Mont Blanc. We had just had dinner on the second evening when an English girl came up to us and asked us if we did not think the position very serious, adding that she and her party were leaving hurriedly for home next day. She showed us some Italian papers, and we were able to make out enough to see that France was in for a big war, and that the return journey would be far from easy. We could get very little information about England, but one visitors' paper which printed a column or two in English told us that "The clergy have received orders to pray quite hard for peace."

We decided that it was wisest to return as soon as possible, and accordingly we took the motor diligence to Aosta the next day, and on August 3rd another to the Great St. Bernard Hospice. Walking down from there we were stopped at the first house by Swiss soldiers with fixed bayonets. The officer came up and asked us several questions about the movements of the Italian troops which were manœuvring on the other side of the pass, but when we had answered these he made no difficulty about letting us proceed, and we were not yet inclined to think very seriously of things. As we went down the valley, however, and saw the numbers of men coming down from the heights, and the notices posted in each hamlet, calling on the Swiss people to remain calm and to carry on their work as far as possible despite the mobilisation, we began to see that Switzerland, at least, was serious. At Liddes, where we stopped for lunch, the innkeeper told us that he had to join his regiment next day, and he gave us some idea of the direction in which Swiss sympathy lay when he said in broken English that though, of course, the Swiss were neutral, "if the French wish to pass through our country—well, perhaps we will let him; but if the German do come —ach, we will punch his head." We found the same spirit at Orsiéres, where a reservist who was bidding a bibulous farewell to his friends, on being assured that we were English and not German, insisted on shaking hands with us many times over, and on getting into the train made offensive remarks about the Kaiser and the German race in general to the obvious discomfort of three very frightened-looking Teutons who were in the same compartment.

At Martigny we found the station guarded by soldiers, and much excitement amongst the crowd at the booking office. We inquired about the possibility of getting through to France, but we got so much contradictory information that we decided to stay the night at Lausanne, which we reached at 11 p.m. Next morning we found that there were already many English people there, several from Chamonix where they had been given the choice of leaving for Switzerland within twenty-four hours or of being detained in France for an indefinite period. They told us that trains were no longer running across the frontier to Pontarlier and that it seemed best to wait for a time in Lausanne. A committee had been formed by one or two men who wanted something to do, and who spent much time in making out lists of names and interviewing the Consul. We also interviewed the Consul. His one piece of advice was to remain quietly where we were; special trains were being organised, but at present it was impossible to get across France. Most people, like ourselves, had return tickets, via Pontarlier, and it was rumoured that there were between three and four thousand English stranded there without beds or food and unable to proceed. We were fortunate in having some English gold, but there were many folk with letters of credit for large sums who were unable to obtain cash and were in considerable difficulties. The Consul, who was also a Swiss banker, cashed small cheques at a discount which varied, it was said, from five to twenty-five per cent. The hotel keepers, however, were very reasonable; they did not overcharge, and they accepted cheques in payment of their account. There was much generosity also amongst the English themselves: men with cheque books offering to pay the bills of those who had none without any guarantee of ever seeing their money again. One man made a point of finding out women who were travelling alone in order to help them. In a few days he was advising and cheering twenty-five helpless females, getting them passports, finding them rooms, etc.

The day after we arrived there was a meeting at the English Club for all those who cared to go. The committee appointed itself, and the Consul was very paternal, telling us to be patient and to wait for the special trains. He also announced that war had broken out between England and Germany.

So we waited for five days, hoping each day for some definite news of the special trains, and unable even to get reliable news from the papers. One or

two parties of men went off to Pontarlier on their own and were heard of no more. Then it began to be rumoured that we might be unable to escape for three months or more, and as the financial question was becoming more and more acute, we had to move from our hotel into cheaper rooms. These we found in a girls' school kept by an Alsatian lady, who took us in for five francs each a day—bed, food, and everything. There were only four schoolgirls, as it was holiday time, but it was a strange experience for two men to take their meals with the girls, madame, and her two daughters, to have to talk French and be corrected for bad pronunciation. Two of the girls were Germans, and they had at first objected to our going, but after the first meal madame told us that they had not expected Englishmen to be gentlemen, but as they found we were we might stay! After that we all got on very well together, and we caused constant amusement by our poor efforts to speak Parisian French.

Meanwhile the committee kept on meeting and assumed an air of great importance and mystery and pretending to have information which they announced could be imparted only at a general meeting at the English Club on August 10th. The information proved to be only that they had no definite information, and at the meeting there was a good deal of criticism of the total ignorance both of the committee and of the Consul as to what was really happening on the French railways and as to when the special trains were to appear. Some of us talked the matter over afterwards and came to the conclusion—since proved to be correct—that the reports as to the difficulties of travelling home were being purposely exaggerated in order to prevent the whole ten thousand or so English who were then in Switzerland from trying to rush home together, since that would have caused serious congestion of traffic and hindered mobilisation. A few at a time could probably get through, we thought, and we therefore decided to make the attempt. On August 11th we went by boat to Geneva, as we heard that that was less crowded than Pontarlier. We had our passports viséd by the French Consul, which cost us ten francs each, and a long wait in a very badly organised crowd, and secured a carriage on the train which left at 5.35 p.m. At Bellegarde, the first important French town, we had to change and have our passports examined and stamped with a safe conduct, and at Amberien we were turned out and had to wait on the platform from 10 p.m. till 1 a.m.

The train which took us on from there consisted of twenty-four crowded coaches and two engines, one in front and one behind. The engines failed to work together, so that when we stopped, which we did at every station without exception, we received most alarming jolts and shocks. The heat as the day went on became terrific, and perspiration streamed down us continually; it was, therefore, a great relief when we reached Dijon at 10 a.m. and found a most excellent déjeuner awaiting us at the buffet at the moderate price of 1 franc 75 centimes, including wine.

The station and town were full of soldiers and various troop trains passed, most of which had chalked upon them, "Train de plaiser à Berlin," for the French are full of confidence in the issue. We left Dijon at 3 p.m., and proceeded slowly towards Paris. It was hotter than ever now, and at each station there was a rush for the tap labelled "eau potable." In one of these rushes a French soldier got left behind, and the fact that he simply ran after the train and caught it again at the next station will give some idea of the speed at which we rushed along.

To make the story considerably shorter than the journey seemed to us, we arrived in Paris at 3.30 a.m., August 13th, having spent thirty-five hours in travelling from Geneva instead of the usual twelve hours or so.

We had to get our tickets numbered for a place in the train to Dieppe on the following day, as only three-hundred English were allowed to travel by that route on each train.

As we had to spend a night in Paris, we were looking for an hotel when we were stopped by a gendarme who demanded our passports. On seeing we were English and had had our passports viséd he at once became very polite and offered to show us the way. Paris was very calm, although at first sight it appeared to be en fête, each shop displaying the tricolour flag, although a great number were closed or only open on certain days each week owing to the fact that the proprietor and assistants were all away with the colours. There were, of course, many soldiers about, and we must have seen types of most of the French regiments in the course of the day, but there were no unusual crowds in the streets, and even the lists of casualties which we saw posted in one or two places only attracted a few women. Shops with Teutonic names displayed, as a rule, a certificate of French nationality.

Next morning we left the St. Lazare Station at 9.33 a.m. for Dieppe, and again travelled in great heat and very slowly, still stopping at every station. In our compartment were some reservists going to join the colours at Rouen, all very friendly and enthusiastic and anxious to share their wine with us. They were very pleased when we sang patriotic songs to them, and one responded with the whole of the Toreador song from Carmen. On arriving at Rouen at 3 p.m. the reservists formed fours, and, headed by the flag, marched off singing the Marseillaise which they interrupted with cries of "Vive l'Angleterre" as they passed us, many of them stepping aside to shake hands with us. We had to wait an hour and a half

at Rouen, and then left for Dieppe, arriving at 7.30 p.m., and having stopped at every station between Geneva and the port.

We had to obtain from the Consul at Dieppe a written permit to enter England, and before we were allowed on board our papers were carefully examined and details entered concerning each one separately.

The crossing (to Folkestone, since Newhaven is closed) was uneventful, but before we were able to land our papers were again examined both on board and on the gangway. We were most thankful to be once more in England after four and a half days' travelling from Lausanne, and especially when we found express trains still running as usual. It is not until such times as these that one realises the advantages of living on an island protected by a powerful navy, where, even when we are at war, things can go on normally to a great extent.

In Switzerland, which has no interest in the squabbles of its neighbours, the mobilisation means a most serious shortage of labour during the busiest time in the fields. Even in ordinary years the regular troops have to help the peasants to get in the harvest, but now that all the able-bodied men are engaged on the frontiers the whole labour devolves on women and children, who are quite unable to cope with the enormous task.

The glimpse of the entire manhood of two nations under arms, of trains loaded with field batteries, transport waggons, and ambulance appliances, of fine bridges destroyed, and of railways carefully guarded at each vulnerable point, and the sound of the Marseillaise sung by hundreds of men all eager to strike a blow at their enemy and ours, have made an impression on me that will not soon be effaced, and I hope that this account of our journey amidst such historic scenes may be of some interest to those who, being at a distance from the actual battlefield, find it difficult to picture what war means to our Continental allies.

H. W.

Change of Address.

Wm. C. Whitworth, M.R.C.S., L.R.C.P., from Royal Cornwall Infirmary, Truro, to St. Agnes, Scorrier, Cornwall.

Dr. H. W. Collier, 83, Finchley Road, St. John's Wood, N.W.

Graham Simpson, Esq., F.R.C.S., from 79, Upper Hanover Street, to 342, Glossop Road, Sheffield.

Surgeon Hildred B. Carlill, M.D., R.N., from H.M. Hospital Ship *Drina*, No. 3, to H.M.S. *New Zealand*, 1st Battle Cruiser Squadron, c/o G.P.O.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

The Biennial Dinner.

Dear Mr. Editor,—Modern methods of travel are taking Guy's men further afield in search of a living and those who leave home are compelled, for reasons of health and further study to return every few years to the old country. Most of them would wish to be at a Guy's dinner, but, like those who arrive in England next year, find that they have arrived in the "off" year. I suggest to you, Sir, that the Guy's dinner becomes an annual affair. I am aware that this would involve a lot of work on some person, but could not professional clerical work be obtained. Will you please ask men, through your paper, what they think of the idea?—Faithfully yours,

C. H. BRANGWIN.

Swatow, China,
July 23rd, 1914.

[We fully sympathise with our correspondent's difficulty, but personally we would strongly deprecate any proposal to hold an Annual Guy's Dinner. We feel sure that it would tend to diminish the enthusiasm of the great mass of Guy's men, and that the Dinner would be only poorly attended. However, it may be that our views are in a minority, and we would like very much to hear the views of our readers on Dr. Brangwin's proposal.—Ed. G.H.G.]

National Relief Fund.

TO THE CRICKET-LOVING PUBLIC.

Dear Sir,—We, the undersigned, as cricketers, ask you to accord us the publicity which only your columns can give, in order that we may make a direct appeal to the vast cricket-loving public on behalf of the Prince of Wales's Fund.

This Fund, which has been called into being by His Royal Highness to meet the countless cases of misery and hardship which must inevitably follow on the heels of war, makes an instinctive and instantaneous appeal to the generosity of the public, and we, as cricketers, know that there is no public so sportsmanlike and so generous as the cricketing crowd.

As the Prince has truly said, "This is a time when we all stand by one another." All of us as a nation are members of a national team.

We have before us as we write the vision of many a fair English cricket ground packed with eager multitudes.

We have pleasant memories of seas of faces which, in happier times, have watched us play.

If only at this moment of trial we could gather in the sums which have been paid as gate-money at cricket matches, those on whom the war has laid a desolating hand would benefit indeed. The wives and families of our soldiers and sailors would at least be secure from want.

It is this thought which has given rise to this particular appeal. We ask all those who have watched us play, and who have cheerfully paid their half-crowns, shillings, and sixpences as gate-money, to step forward and contribute over again their half-crowns, shillings, and sixpences to the Prince's Fund, out of gratitude for the enjoyment the cricket field has given them in the past.

Let everyone who has followed cricket recall to mind the matches he has witnessed and enjoyed, and let each one contribute according to the pleasantness of his memories. Then we shall have for those whom the war has robbed not only of happiness, but even of the means of livelihood, a truly royal sum. Without any undue spirit of self-importance, we may perhaps say that we have contributed not a little to the interest the public takes in cricket, and therefore we make this personal appeal from ourselves to all those who love the game to send whatever they can spare to H.R.H. The Prince of Wales, Buckingham Palace, London, S.W. — Yours faithfully,

J. W. H. T. DOUGLAS.
F. R. FOSTER.
F. H. GILLINGHAM.
W. G. GRACE.
HARRIS.
T. HAYWARD.
G. HIRST.
J. B. HOBBS.
G. L. JESSOP.
W. RHODES.
R. H. SPOONER.
P. F. WARNER.
F. E. WOOLLEY.

[Subscriptions should be addressed to H.R.H. The Prince of Wales, Buckingham Palace. The letters need not be stamped. A form for use when sending donations will be found in our advertisement columns.]

The Guy's Dental Unit.

DEAR SIR,—I shall be glad if you will allow me through the medium of the GAZETTE to offer my thanks to Messrs. Pritchard, Mallet, and Lowein, who were to have formed my first dental unit, and also to Sir Cooper Perry for the great trouble they took in preparing my outfit from Guy's.

On the outbreak of the war it seemed probable that Wimereux and Boulogne would be base hospitals for the returning English wounded, and I promised the English Red Cross that I would remain at Wimereux till wanted. But the German advance brought Boulogne within the zone of military operations, and so it became unfit for a base hospital, and the wounded were diverted along other lines. Gradually we became cut off, and a week ago letters ceased to reach us. Yesterday I was one of the last English in Wimereux, and I had to leave behind me, in the post, about £125 in notes and money values. I hope this may reach me some day. Meanwhile France is no place for the unattached Englishman who is not well supplied with funds, and the latter will change hands if he meets the Germans; protest is likely to be followed by final settlement in the form of a bullet.

As far as I can judge, for dental surgery the best base is London, and the hospital that is most favourably situated in railway communication is close to London Bridge. I shall promptly go to Guy's to see what special cases they have received, and to thank Mr. Bull for all the trouble he took in getting together my workroom outfit.—I am, dear Sirs, Yours sincerely,

Hampstead, F. NEWLAND-PEDLEY.
September 4th, 1914.

The Adulteration of Drugs.

DEAR SIR, — In the GAZETTE of March 14th last (page 114, col. 2, par. 3) adulteration of calamine was described. At the hospital with which I am connected there seemed to be no carbonate of zinc in the drug at all. The sellers acknowledged this, and blamed the manufacturer, but it was easy to discover the fraud. Are their manufacturers defrauding us (and them) in any other drugs, I wonder? Could the GAZETTE give a few probable examples, with the (not too difficult) tests.—Yours very truly, T.C.
August 27th, 1914.

With reference to the above letter, Mr. Finnemore, the Hospital Pharmacist, writes, "I should not like it to be thought that there was any suggestion of fraud in my reference to calamine in the Dispensary Annual Report. This article occupies a unique position in that, not being included in the Pharmacopœia, there is no official standard for it, and, therefore, in the absence of any specification on the contract form or on the order, every manufacturer can make his own standard, and as long as it possesses the desired pink colour and does not contain soluble deleterious compounds, it would be difficult to show that any prejudice had been suffered, always provided that the price charged for it were not out of relation to its composition. I should consider it a fraud if the bulk did not agree in composition with the sample from which it was bought or if the price paid for it were that suitable for zinc salts and nothing but barium sulphate were supplied. If a definite product be required it would be advisable to specify the Codex article.

As to suggesting articles that can be tested in the manner indicated in the above letter, it would be difficult to do much, because drugs and galenical preparations are often the most complex bodies, and their testing cannot be done in a simple manner. Inaccurate results would be liable to inflict undeserved censure on all parties concerned. If your correspondent cares to write to me and give details of his method of purchasing, I could give him a list of those articles supplied to this and other hospitals which I have found to be deficient in strength or quality.

Acute Gonorrhœal Urethritis.

CLINICAL LECTURE BY RALPH THOMPSON.

Gentlemen,—Gonorrhœal urethritis is that inflammation of the urethra which is associated with the presence of gonococci. In a smear preparation of the purulent discharge the gonococci, if the inflammation be in the acute stage, are grouped together in masses. If the inflammation is of a chronic nature, the gonococci may be difficult to detect, owing to the fact that they occur then as isolated and quite small groups. Frequently, in cases of chronic urethritis, the gonococci disappear, and only streptococci or staphylococci are found. These cases of chronic gleet should be regarded as gonorrhœal in origin, as undoubtedly the pus at one time contained gonococci.

In a case of purulent urethritis it is well worth while to make an examination of a smear preparation with a high power. Three stages of the acute condition may be recognized by this means. The first, in which the urethral epithelial cells and polynuclear leucocytes are found not only surrounding but also containing large numbers of cocci. This appearance is associated with the height of the malady. The second stage shows gonococci isolated, and few epithelial cells, but many leucocytes. Later on the epithelial cells again increase in quantity, and other pus organisms may appear.

The gonococci stain well with methylene blue. They do not, however, take Gram's stain. For purposes of cultivation it will be necessary for most of you to seek the help of the bacteriologists, but a microscopical examination of the pus should never be neglected, as by it you may frequently recognize the stage which the disease has reached, and whether or not it is being treated successfully.

The gonorrhœal organisms offer a very feeble resistance to antiseptic factors, and this fact should always be remembered, as it is of great importance in considering the question of treatment. They are killed in the laboratory in a few hours by a temperature so low as 105° F., and in some minutes by a temperature of 130° F. They die in a few hours if subjected to a temperature of 32° F., viz., freezing-point.

These points, which, perhaps, may be regarded as falling within the province of the bacteriologist, have been mentioned because it would appear that a knowledge of them might make some of you consider that gonorrhœal urethritis is a disease which would easily yield to treatment. It has been said that gonorrhœa will be cured naturally within four weeks, or even three. There is thus a great temptation to leave cases of gonorrhœa either to themselves or to the patients, or to chemists. Of this threefold choice the first is considerably the best. But whilst on the one hand you may, in certain rare cases, treat the disease quite adequately by merely watching its progress, on the other hand you may in a great many more cases watch the disease run a chronic course, become a source of worry and anxiety to the patient, a constant source of infection to other people, the starting point of an extremely painful form of rheumatism, of which we have an example in number 14 Astley Cooper at present, the precursor of a stricture which, unless treated, will inevitably shorten the life of the patient, and the focus from which inflammation may spread to the genital organs, and lead to sterilization with its serious consequences upon the next generation.

It may, therefore, be put forward as an axiom that all cases of gonorrhœa which are seen by you in your capacity as medical man should be treated as efficiently as possible by you. In many cases you will have to be very patient before you finally achieve a cure. In some cases you may, unfortunately, fail to effect a cure, but in a great number of cases, with patience and determination to cure, you will be rewarded by eventually seeing a perfectly healthy urethra and normal urine.

As this lecture is chiefly concerned with certain points in the treatment of gonorrhœal urethritis, we shall not have enough time to consider the symptoms of the condition at all fully. These must, however, in part be considered; but before this it is necessary to examine the anatomy of the urethra as it affects clinical conditions. There can hardly be any part of the body so important in the correlation of anatomy and clinical conditions. The urethra is an S-shaped tube eight inches long; it is divided into three parts: the first part, about one inch long, lies in the prostate, and is directed downwards and forwards; the second part lies between the two layers of the triangular ligament, also runs downwards and forwards, and is about half an inch long. The spongy part lies in the spongy portion of the penis and is six and a half inches long. The prostatic portion receives the two common ejaculatory ducts, thus connecting the urethra with the vesiculæ seminales and the testicles, and also the ducts

of the prostate gland itself, some ten in number, on each side of the veru montanum.

The membranous portion receives the secretion of the large gland; but the spongy portion, close to its proximal end, receives the secretion of Cowper's glands, which, you will remember, actually lie one on each side of the membranous part of the urethra. Sometimes the ducts of these glands pass for a considerable distance under the mucous membrane of the urethra.

The spongy part of the urethra is remarkable for the large number of orifices belonging to the glands of Littré, which for the most part lie on the dorsal aspect. These glands and ducts likewise appear in the membranous part. In addition there are depressions in the mucous membrane of the urethra, called "lacunæ urethrales." These depressions lie somewhat obliquely, so that their orifices face the same way as the direction of the urethral canal.

The terminal part of the urethra opens at the meatus urinarius, which is a slit-like vertical orifice which may be in certain cases much smaller than usual, owing to the growth of a ventral septum over the lower part of the orifice. Behind the meatus lies the fossa navicularis, which is a dilated part of the urethra, and is guarded behind by a fold of mucous membrane.

The mucosa is stratified, and has many superficial columnar cells. There is a good deal of elastic and muscular tissue beneath the mucosa.

When fluid is not being passed along the urethra the urethral mucous membrane is thrown into extensive folds.

From this description of the anatomy of the urethra it will be readily understood that, if a purulent inflammation should occur, the pus will tend to collect, and remain in the urethra, and that it will by no manner of means be washed away by the flow of urine during the act of micturition. Let us now turn to the clinical manifestations of gonorrhœal urethritis.

The patient having exposed himself to infection notices great pain on micturition described usually as a scalding sensation, followed shortly by a thick purulent discharge from the meatus, this discharge is not infrequently sanguineous.

The pain varies, however, in different people; sometimes there may be very little, in which case both patient and medical man may be misled unless a microscopical examination is made. Or the pain may be so great that the patient cannot pass his water, and retention of urine in the bladder occurs. The treatment to be adopted here is of great importance. A hot bath, the administration of a large dose of laudanum, the irrigation of the urethra, and the administration of a general anæsthetic should all be considered, and, if possible and necessary, tried. In some cases it may be absolutely necessary to pass a catheter, in which case the urethra should be irrigated beforehand, and the greatest care as regards asepsis and gentleness exercised during the passage of the catheter, and the bladder washed out with some mild antiseptic after the urine has been drawn off. It need hardly be said that anyone who attempts to pass a catheter for retention during an acute attack of gonorrhœa incurs a grave responsibility, and unless he knows how to deal properly with catheter cases, had better not undertake the treatment.

An out-patient who attended at the beginning of this year was regularly catheterized for acute retention during an acute attack of gonorrhœa for some three or four days without any spread of the inflammation backwards, or any untoward symptoms occurring.

The pain, which as we have just seen, varies in intensity, and the discharge containing gonococci are the main symptoms of gonorrhœal urethritis.

It is necessary now for you to examine the patient, and it will be well if you examine the case quite methodically.

The essentials for an examination in such cases are: some specimen glasses holding at least half a pint, as slender as possible, and an efficient irrigating apparatus fitted with Wyndham Powell's funnel and protector. The irrigating apparatus should be capable of being raised to a height of at least a metre and a half above the patient's penis when the patient is recumbent, and capable of being lowered to the level of the penis. Further details of the use of such an irrigating apparatus may be gathered in the Genito-Urinary Out-Patient Department.

The patient should be made to lie down, and at least two smear preparations ought to be taken of the purulent discharge. Examination and treatment now proceed hand in hand. There may be a long foreskin; if so, draw it back and wash it and the glans with some fluid, of which weak permanganate is perhaps the best, and get the glans and inner surface of the prepuce as clean as possible—that is, absolutely clean and free from smegma. The smegma particularly collects, and adheres behind the corona, between it and the attached part of the prepuce. Every trace of dirt must be washed away, and usually a pressure of the irrigation fluid of a quarter of a metre is quite

sufficient for this purpose. On the surface of the glans a pressure of three-quarters of a metre is sufficient with Wyndham Powell's nozzle to produce splashing, which is not desirable. Care must always be taken to replace the prepuce in its proper position after the treatment and examination have been carried out.

A patient presented himself suffering from an attack of acute gonorrhœa. Neglect to replace the drawn-back prepuce resulted within three days in a severe paraphimosis—a very undesirable and quite unnecessary complication of gonorrhœa.

The glans and prepuce having been examined and irrigated, you must next turn your attention to the meatus urinarius. This may be, as previously pointed out, very small, and in such cases, though it may be difficult to convince the patient of its necessity, it will be well to advise a meatotomy. This is a very simple and, if done properly, a bloodless operation. One blade of a pair of scissors is inserted into the meatus urinarius, and the septum, which is responsible for the small opening, simply divided towards the frænum for a distance varying from one-eighth to a quarter of an inch. If the cut is in the middle line there will be no bleeding. Meatotomy is better than dilatation; the meatus is the least dilatable part of the urethra, and if dilated causes much pain. Care must be taken that the meatus is kept widely open.

Sometimes slight degrees of hypospadias may be associated with a very small meatus, and if the opening can be enlarged by a small incision so much the better, but such cases must be considered on their merits. The condition is mentioned, as it undoubtedly produces difficulties in the efficient treatment of a gonorrhœal urethritis.

The meatus being of a reasonable size, must now be carefully irrigated with the nozzle situated just outside the meatus, and the meatus being kept as widely open as possible.

Now grasp the penis near the glans, taking care to keep the prepuce well back between the index finger and thumb of the left hand. Have the irrigating fluid at a height of three-quarters of a metre, and placing the point of the nozzle into the meatus turn on the fluid, taking great care that there is a free exit for the fluid from the urethra. The fluid which is generally used is weak permanganate of potash. The fluid should be pink and translucent in a tall vessel holding four pints. It is then not too strong. I have tried many fluids, but find none so satisfactory as this. But quite as important as the nature of the solution which is used is its temperature. For some years now the temperature I have been accustomed to use has been 120° F. It is well not to start irrigation with fluid at such a high temperature as this, but never should the temperature of any irrigating fluid be less than 110° F. at the commencement of treatment. Therefore you should begin to irrigate the urethra with fluid at a temperature of 110° F. and gradually increase it to 120° F., or a little less if the patient cannot endure 120°. This irrigation should be continued for five or ten minutes, and the great result which follows from the use of such irrigation is that the patient loses his pain. The urethra having been irrigated, the patient is instructed to pass his water into a glass. If there is no sign of purulent discharge, then it is clear that one is dealing with a case of anterior urethritis.

The urethra is divided into two parts by the membranous portion, which, you will remember, is surrounded by the compressor urethræ muscle. The part which lies behind, *i.e.*, the prostatic part, is called the posterior urethra; the part which lies in front is called the anterior urethra. The posterior urethra is named also the prostatic urethra. The anterior part is called also the spongy urethra. Except during the emission of urine or semen, the compressor is tightly closed, and pus does not normally press backwards from the anterior to the posterior urethra, but occasionally it may do so, in which case the posterior urethra becomes affected by the inflammation, and thus also the ducts of the vesiculæ seminales; the prostate and the testicles may become also involved by the inflammatory process. The only glands of any size which could be affected when the gonococcal inflammation only affects the anterior urethra are Cowper's glands. If these are affected, however, it is a comparatively small matter when compared, for example, with a gonorrhœal affection of the testicles.

So it will be clearly seen that it is desirable for the medical man to know whether he has got a simple anterior urethritis with which to deal, or a urethritis of greater extent involving not only the anterior but also the posterior urethra. For this purpose what is called the two-glass test is frequently undertaken. There are two objections which are of paramount importance, and which have compelled me to cease to use the two-glass test as commonly adopted.

The usual two-glass test is thus conducted: The patient, at the beginning of the examination is instructed to pass his water into a tall speci-

men glass, which he does, until a height of three inches or thereby is reached. He is then instructed to cease passing his water, and then to pass the remainder into another specimen glass.

The two objections which present themselves to any one of even slight experience are these: The extraordinary difficulty of stopping the flow of urine when once commenced, and of starting it again after being stopped. However, if this acrobatic performance is managed properly, the urine in the glasses is examined, and if the first glass contains pus and the second does not, then, clearly, as the flow of urine must have followed all the pus in the anterior urethra, the posterior urethra cannot be affected. If, however, both glasses contain pus as well as urine, then the posterior urethra is affected as well as the anterior.

The second objection is this: If the first flow of urine succeeds in removing all the pus from the anterior urethra where the mucous membrane is deeply pitted, and thrown into folds it may also remove the pus from the posterior urethra where the mucous membrane is much smoother. Further, the first flow of urine may not discharge all the pus from the anterior urethra, in which case there may be pus in the second glass. In the first place, then, by the usual two-glass test, an anterior urethritis may be diagnosed when there is really also a posterior urethritis; and in the second place a posterior urethritis may be diagnosed, when there is only an anterior urethritis.

The best two-glass test I have ever seen, in which the first specimen was cloudy, and the second quite clear, indicating only an anterior urethritis, was associated with an enlarged right vesicula seminalis and a right epididymitis which, whatever was the result of the two-glass test, indicated that the posterior urethra was also affected. Here a warning may be given: The question is not—Is there an anterior urethritis or a posterior urethritis?—but—Is there a posterior as well as an anterior urethritis? The two-glass test then, as usually carried out, is at once difficult and fallacious. I have previously described the proper modification of it, which may be summed up as follows:—

First wash out the anterior urethra as thoroughly as possible so as to get rid of all pus from it, then instruct the patient to pass his water without stopping the flow, and if the fluid is clear then the posterior urethra cannot be affected, but if it contains pus then it certainly is affected. Treatment and examination have thus been combined.

This irrigation with hot fluid may be repeated twice a day for a week or ten days, and should have usually affected a cure of an acute attack within three weeks. By this means a patient was completely cured the other day within ten days of the onset of the attack. One disadvantage of frequent and prolonged irrigation is that unless every care is taken the nozzle resting in the meatus may produce soreness and pain, but with care this can be avoided.

Thus, supposing that the posterior urethra is affected as well as the anterior urethra, you will base your diagnosis on the following signs and symptoms:—

After the anterior is washed out the urine will contain pus when discharged into a specimen glass.

A rectal examination should always be made. It is important that this examination should be made as far as possible with patients in a constant position. The best position is with the patient leaning on his arms and hands on a couch with his feet wide apart, and hips flexed. In this attitude there is much better exposure of the anus, and the examining finger can enter it much more easily than in other positions.

By this means the prostate or seminal vesicles may be gently examined, and any inflammatory swelling indicates posterior urethritis which has spread to these organs. Or epididymitis and possibly an acute hydrocele may be present. This is very rarely bilateral. Posterior urethritis having been diagnosed the question of its treatment must be considered.

The same principle of letting very hot fluid flow freely over the affected urethra as was adopted for anterior urethritis must be carried out with certain modifications.

In order to be sure that the fluid which is being used for irrigation shall really enter the posterior urethra, it is necessary for you to realise two facts. Firstly, a pressure of one and a half metres of fluid is necessary in order that the fluid may pass the compressor muscle and enter the posterior urethra, and secondly, any fluid which under such pressure reaches the posterior urethra must of necessity enter the bladder. Such irrigation, therefore, amounts to a bladder wash-out and the free flow of irrigating fluid depends not upon its exit from the meatus urinarius which should not happen, but upon the capacity of the bladder. Not more than half a pint of fluid should be introduced into the bladder, and this is almost the only occasion, namely, in the treatment of a posterior urethritis, when such a large

quantity of fluid should be introduced into the bladder. For all other affections of the bladder not more than six ounces of fluid should be introduced.

The patient must then pass the fluid from his bladder, and the first washings may be opaque, owing to the mixture of permanganate with the residual urine in the bladder. After the first washing the process may be repeated two or three times.

I have never seen anything but good results from these irrigations. I have never seen any spread backwards or to adjacent organs or ducts result from these irrigations. On the contrary, whilst I have regretted the omission of irrigation, I have never had cause to regret its use.

With regard to drugs, my own experience is that copaiba resin is the best drug to use. It should be given in capsules gr. x. t.d.s., or even in larger doses. Copaiba is, however, an objectionable drug for a patient to take, but this objection was balanced by the patient taking each dose some minutes after a heavy meal. As copaiba is now the only drug which I use, I do not propose to consider any others.

With regard to the lotions for irrigation, two rules may be remembered. Never use for another person's urethra any lotion which you would not care to use for washing out your own conjunctival sac, and as regards the temperature, if you can *bear* your hand in the irrigating fluid *with* discomfort, that fluid is not too hot for the patient's urethra. Remember, also, that to be of any use the irrigations must be frequent—twice a day, if necessary—and must be prolonged at each sitting, *i.e.*, ten or fifteen minutes.

With regard to the urine, the presence of phosphates and the copaiba resin producing a cloudiness, may mislead the patient, but should not mislead the medical man, as to the presence or not of purulent discharge in the urine.

Some important complications of gonorrhœal urethritis may now be mentioned and partially considered. They are prostatitis, vesiculitis, epididymitis, and gonorrhœal rheumatism.

An analysis of the cases of gonorrhœal urethritis which have attended the Genito-Urinary Department during the years 1911 and 1912 respectively, will be, perhaps, of interest in this connection so that you may know the possible chances of occurrence of these complications. There can be little doubt that in a matter of this nature hospital statistics will err in this respect. Patients who will take no notice, or only very little notice, of an ordinary uncomplicated attack of gonorrhœa, and who will not take the trouble to come to any hospital, will, of course, come if they think that their own particular case is not going on satisfactorily, and one is not surprised to find that the complications have a much higher proportion in hospital than in private practice.

Analysis—1911 - - 106 cases.
1912 - - 123 „

Total - 229 cases.

Youngest age at which disease was contracted, 15.
Oldest „ „ „ „ „ 82.

Period of incubation—
Shortest - 1 day.
Longest - 3 weeks and perhaps over.

Complications—			Per cent.
Hæmaturia - -	2 cases	less than	1
Retention of urine -	1 „	„ „	·5
Suppurative conditions—			
Prostatic abscess -	2 „	„ „	1
Periurethral „ -	1 „	„ „	·5
Testicular „ -	1 „	but + injury.	
+ Syphilis - - -	4 „	less than	2
Orchitis, right - -	16 „	„ „	8
left - -	20 „	„ „	10
uncertain side	10 „	„ „	5
Bilateral orchitis -	2 „	„ „	·1
Hydrocele, right - -	1 „		
left - -	1 „		
uncertain -	3 „		
Paraphimosis - -	5 „	- -	2
Cystitis (?) - - -	2 „	less than	1
Rheumatism - -	10 „	„ „	5
Prostatitis & vesiculitis	4 „	„ „	2
Posterior urethritis at further complications	3 „	„ „	1·5
Endogenous ophthalmia (Ormond) - -	1 „	„ „	·5
Stricture - - -	1 „	„ „	·5
Complications - -	86 „	or	38

I repeat that these figures and percentages are much higher in my experience in hospital than in private practice.

An extension of the gonorrhœal urethritis backwards to the posterior urethra is indicated clinically by an increased frequency of micturition. As has been already indicated, an extension backwards is to be feared, because it may produce a still further extension to the prostate, vesiculæ seminales, and testicle. With extension backwards to the prostate and vesiculæ seminales, the patient may find it painful to sit down, and defæcation may be painful. When a rectal examination is made, one or both vesiculæ seminales may be discovered tender

and swollen; the swelling is smooth at first, but as the disease progresses may become nodular; each nodule, however, is smooth.

The main symptom of an orchitis is the sudden diminution in the amount of discharge from the meatus urinarius. If during treatment the discharge suddenly ceases, suspect the possibility of orchitis, and adopt treatment directed to the testicles at once. I have never seen a case of uncomplicated gonorrhœal orchitis go on to suppuration, although there is one recorded in my analysis, but in this case there had been previously a very considerable injury to the affected testicle. Therefore, there will be no harm in applying hot fomentations to the scrotum, and instructing the patient to go to bed and seeing that his testicles and scrotum are kept well up.

Whenever there is any immediate likelihood of an inflammation of the testicles, always have the scrotum and testicles well supported and as high as possible. The patient should be sent to bed and an aperient administered. At present I believe a gonorrhœal inflammation of a testicle leads to atrophy of the organ. The part usually affected is the globus minor of the epididymis. The swelling is very painful and tender; hard, smooth, and usually localised, though there may be a hydrocele associated with the epididymitis.

Obituary.

ALEXANDER RATHOUSE.

We deeply regret to have to record the death, on September 8th, of Alexander Rathouse. He had been admitted ten days previously into one of the medical wards with pneumonia. Although he was acutely ill, the end came suddenly and unexpectedly.

Rathouse, who came from South Africa, entered the School in October, 1913, and took the London M.B. course. He had already passed his Preliminary Science as a student at the Transvaal University College, Pretoria, and had obtained the B.A. (with honours) of the Cape University. His work in the School had been exceptionally good, and he was regarded as one of the most brilliant of the first-year men. He was a member of the Officers' Training Corps.

Personally he was very popular with all his contemporaries, and was a representative of the best type of men in the hospital. The news of his untimely death was received with sorrow and consternation by all his friends. We tender our very sincere condolences to his parents who were still in South Africa at the time of his death.

Some Further Therapeutic Points.

Being an Address by HERBERT FRENCH, M.A., M.D. (Oxon.); F.R.C.P. (Lond.); Physician to Guy's Hospital.

(*Continued from page 330.*)

The value of external heat to babies who are ill

Can hardly be exaggerated. In these days of open windows and open-air treatment, so very important to adults, there is a considerable tendency to think that babies need identical treatment in this respect. This may be true of healthy babies, infants, and young children, but it certainly does not apply to infants who are sick. Let me try and emphasize this by pointing out that if one were to cool down the external tissues of an elephant so that they were chilled to a depth of two inches all round the animal it would be sometime before this external cold would have any direct influence upon the underlying organs because the bulk of the animal is so great; if, however, one were to cool down the external tissues of a baby to a similar extent the viscera must necessarily become affected by the cold almost at once; the only way to prevent their becoming affected thus is for additional calls to be made upon heat production in the child's body and this entails a repeated drain upon what one may call the fuel of the engine. Sick children take food badly as a rule and, broadly speaking, anything which can conserve their fuel is good for them. It is probably in this way that oiling the surface of the child's body does good; the oil is a bad conductor of heat, and many a marasmic child has been saved by the external application of oil not so much by reason of any of the oil itself becoming absorbed as by reason of the resultant saving of heat loss and thus of fuel consumption. A greater proportion of the food taken becomes available for the intrinsic service of the body organs. One can do a good deal more towards saving the infant's fuel in a similar way by taking care not to expose the body to external cold; if an examination of the chest has to be made it should be done in a very warm room or near a fire, and not at what may be called the ordinary temperature of a ward. Infants and young children who are ill often do best in rooms which to healthy adults seem oppressively hot. This is by no means incompatible with proper renewal of the air in the room if the ventilation is seen to properly; it may sound heresy now-a-

days to say so, but I would rather nurse most sick infants in a hot room even if it were stuffy than in a cold one that was well ventilated.

A simple expedient for maintaining the external warmth of a baby whilst at the same time allowing it fresh cool air to breathe is now used extensively in Guy's Hospital, and this is by means of a cradle over the child, two or three electric lamps being suspended within the cradle. A blanket covers the infant up to the neck; the face is exposed to the ordinary fresh air of the ward, a small cradle is placed outside the blanket covering the child's body, within the cradle are hung some ordinary electric lights; the cradle is covered with one or more blankets which are well tucked in round the bed; the electric wire of the lamps passes in beneath them; the electric switch is turned on, and the temperature within the cradle watched by means of a thermometer.

I am, of course, speaking of this treatment in a broad general way; one would not use it in conditions of high fever, for example; but it is most beneficial in the treatment of marasmus, diarrhœa, and vomiting with a tendency to collapse, ordinary bronchitis without high fever, and in many other similar circumstances; and the heat loss prevented by it does a great deal towards accelerating the child's recovery.

Radium emanations in rheumatoid arthritis and in diabetes.

A great deal is being written now-a-days in connection with cures effected by radium and its emanations, even in the lay press; and it is difficult to make sure what is real amongst the statements made and what is mere commercial advertisement. I do not propose to enter upon the great value of radium in the treatment of rodent ulcer and malignant disease, but I should like to tell you that I believe radium emanations are of very real value in the relief of certain cases of arthritis deformans or rheumatic arthritis, and in some cases of diabetes mellitus. Precisely how the emanations act is quite unknown; it may be that they behave in some way merely as intestinal antiseptics do, or it may be that like radium itself they have the power of causing cells and tissues which have taken on an erroneous mode of growth and metabolism to return to normal ways. As consulting physician to King Edward VII.'s Radium Institute in London I have had the opportunity of watching several cases in which after other forms of treatment had failed, both chronic joint lesions and diabetes mellitus have been greatly alleviated if not absolutely cured by drinking water containing the radium emanations daily over a period of weeks or longer. I should like to say in this connection that King Edward VII.'s Radium Institute is entirely different to any of the commercial or money-making concerns, some of which have made use of the Radium Institute Reports for commercial advertisement purposes. The Radium Institute was founded at the direct request of King Edward VII.; it was endowed by private individuals; it possesses the largest single stock of radium in Europe and is placed at the service of medical men and their patients without any profit being sought. Well-to-do patients are charged small fees which go into a common fund and help towards the precisely similar treatment of poor patients who are seen at the institute without charge. No patient is seen or treated at the institute except upon the introduction and, if possible, in the presence of his own medical attendant, and any medical man is free to take his patient to the Radium Institute in this way. The only limitations are, first, that the patients have to be taken in rotation because of the limits to the number of pieces of apparatus available, it being possible to treat only a certain number of cases each day; and secondly, the necessary restriction that the radium itself, being so enormously valuable, is not allowed to be borrowed away from the institute itself. Emanations, however, can be sent by post, for though derived from radium and having the same action as the radium itself, they are not radium; they are given off by radium, and by means of a special apparatus at the Institute they are drawn off and absorbed into water; the latter can be charged up to a certain point with emanations, and, subject to the ordinary restrictions of supply, the resultant "radium water" is sent to the doctors who wish to use it. Unfortunately, the emanations pass away from the water fairly quickly, the strength of the latter as regards emanations falling to about half the original in two or three days and becoming weaker and weaker each subsequent day. By arrangement, however, limited only by the supply that the Institute can produce, the radium water can be sent out for the use of patients fresh each day by post. The dose required is from 250 to 500 cubic centimeters which the patient drinks either all at one time, or preferably, perhaps, in three doses during the day, this being continued for weeks or months according to the chronicity and severity of the case. The cost, when a supply can be sent at all, is in the region of three guineas a week, in addition to an original consultation fee to the institute of two

guineas. Some patients, of course, may derive little or no benefit; in most cases of rheumatoid arthritis that I have seen, however, the changes become arrested in a few weeks, and in some cases people who were absolutely crippled to begin with have become able to use their joints in a way which at first would have appeared permanently impossible. The same applies to some cases of diabetes mellitus; perhaps the majority do not derive benefit from the radium emanation water, but some at least have been able to return to ordinary active life with freedom from acidosis and comparative freedom from sugar, when previous treatment by diet and by drugs had failed to bring about any particular improvement at all. The difficulty in all these cases is to give statistical proof of the value of the treatment. In many instances there is bound to be disappointment if hopes are raised too high beforehand; if, however, the patient is prepared for the possibility of there being no improvement at all, one can at least say that there will be no detrimental effect, and now and then a case will be benefited to an extent which, so far as one is able to judge in a broad way, would not have been brought about by other measures at present known.

The Intensive Iodine Treatment for Phthisis, Peripheral Tuberculosis, and other Chronic Microbial Infections.

The treatment I am about to refer to is very probably familiar to some of you already, but in case it is not I should like to draw attention to it, for it has proved of very material service to a number of cases in which I have tried it both in Guy's Hospital and elsewhere. Who originated it I do not know; some tell me that it was first devised in Scotland, others that it came originally from Switzerland, but it was Dr. Reeve who first brought it to my notice; he has written about it recently in *The Practitioner* for September, 1913, page 391. I was already trying the treatment before that paper was published, and although it is too early to boast much of the results, there can be no doubt that almost all the cases who have tried it have been benefited by it, and notwithstanding the comparative nastiness of the treatment itself, many of the patients have asked to continue with it after it has been omitted temporarily. Patients, for instance, who have had the treatment in the wards and have afterwards become out-patients, have voluntarily asked to be allowed to go on with the treatment under out-patient supervision.

Iodine is now well known as a very potent germicide, for which purpose surgeons use it locally in preference to almost any other application in preparing the skin surface for operations. One cannot, however, administer any large quantity of free iodine by the mouth without irritating the gastro-intestinal tract and producing vomiting and diarrhœa. One can, however, give large doses of iodide of potassium by the mouth, and after this has been absorbed one can give chlorine water, which is also absorbed, the chlorine breaking up the potassium iodide to form potassium chloride and free iodine. The idea of the treatment is to liberate free iodine in this way in the blood and in the tissue juices so that wherever the free iodine is present in close proximity to bacteria the latter will be at least inhibited in their rate of multiplication even if they cannot be directly killed by the small quantities of iodine present at any one time.

The method of carrying out the treatment is as follows: The patient takes a single dose of potassium iodide in the morning, say about 8 a.m., the amount given to start with being generally about 30 grains at a time, though if the patient can take it readily there is no reason why double this quantity or even more should not be used. Sufficient time is allowed to elapse to allow all the iodide of potassium to be absorbed. Unless the patient's digestive processes are unusually slow the whole of the potassium iodide will have left the alimentary canal at any rate within six hours, and it has been found by investigation that it does not become eliminated from the system by the urine or elsehow within twenty-four hours. At 2 p.m., therefore, one can give the first dose of chlorine water. If one gives the chlorine water earlier than this one finds sometimes that the patient is almost immediately sick, bringing up vomit which is blue as the result of the liberation of free iodine in the stomach, the iodine in its turn giving the typical blue colour with the starch in the food. One can repeat it at 4 p.m. and at 6 p.m. Next day potassium iodide is again given at 8 a.m., and the chlorine water repeated at 2, 4, and 6 p.m., and so on for many days or weeks. It is found best to give the chlorine water an hour and a half or more after the last meal; if it is given immediately after food it is apt to produce vomiting, but some milk may be drunk after each dose of chlorine water without

detriment. The chlorine water itself is prepared according to the following formulary—

℞ Potassii Chloratis ... .. gr. 60
Acidi Hydrochlorici Concentrati ℥. 120

Place these ingredients in a dry bottle, allow the reaction to proceed for 15 minutes, and add water gradually to 24 ounces. Dose: 1 ounce to be taken in plenty of freshly-made lemonade.

Certain precautions are needed in connection with it, however, for when newly made there is often far too much free chlorine gas in the bottle to allow of the patient's swallowing the liquid without at the same time inhaling chlorine gas which irritates the larynx and bronchial tubes and produces oppression in the chest and much coughing and spluttering. It is a good plan to leave the stopper out of the bottle for 24 hours or more after the chlorine water has been made, and then for the patient to start at the first attempt with a very small dose such as a teaspoonful or less, diluting it well with lemonade to begin with. The patient will soon learn how little he has to dilute the chlorine water to make it possible for him to drink it, and after the first day or two he will also learn how to tell when the chlorine water is, as it were, ripe for ingestion. It is true that a certain amount of the chlorine is lost in this way, but sufficient remains in solution to effect the purpose desired provided the bottle is not left longer than is just sufficient to make it possible for the patient to drink its contents when diluted with lemonade. The dose to be aimed at, then, is 1 ounce at 2 o'clock, 1 ounce at 4 o'clock, and 1 ounce at 6 o'clock. Some authorities aim at giving even more than this, but, upon the whole, doses of 1 ounce are the most satisfactory.

The patient should be prepared for two separate kinds of temporary ill-effects ; the first depends upon the iodism which ensues ; in some cases symptoms of iodism are absent or very slight, but frequently there is headache, running of the eyes and nose, spottiness of the skin, and some depression which, if the patient were not prepared for them beforehand, would make him certain that the treatment was making him worse. As a rule, however, without any change in the treatment the symptoms of iodism pass off by themselves in ten days or a fortnight, and although cough and expectoration may be temporarily increased ; there is often decided red tinging of the sputum at first in phthisical cases which may lead to alarm; these presently diminish, patient's weight increases, the temperature gets less, and the patient himself feels that he is very decidedly getting better. The other type of ill-effect that may ensue is frequent action of the bowels or a tendency to vomiting; if these occur, the treatment may be omitted for a day or two and then begun again.

There will, of course, be cases in which it is found impossible to go on, and, as with any form of treatment, there will be cases in whom no improvement results. There are, however, a sufficient number of others in whom the benefit is so marked that I am sure that some of you may wish to try this intensive iodine treatment, and it is on this account that I bring it to your notice.

Guy's Nurses with the Expeditionary Force.

Matron's Office.
Sept. 8th, 1914.

As may be expected, news from our Guy's Past and Present Sisters and Nurses who have joined the Q.A.I.M.N.S. is very meagre, the efforts of the censor not being relaxed in our favour and the interest of the Gazette. Their address remains, No. —, General Hospital, Expeditionary Force, War Office, London.

Miss Hills (*of the Guy's Institution*), who in the first instance had to report herself at Colchester, is evidently abroad. Her portrait appeared among a large group of nursing sisters in one of the daily papers. Her hospital is No. 7, as above.

Misses Owens, Mann, Prince, Waters, and Sharwood, who left on August 12th and joined No. 1 Hospital, were made welcome in Dublin by many friends of Guy's, and there met, among others, Miss Finnis, late Matron of Market Harborough Cottage Hospital. According to letters and the testimony of a photograph they set sail for ——. Writing a few days ago they were still "on board," with 250 Nursing Sisters. All reported as well and wanting letters, daily papers, and news of Guy's.

Our party of August 17th evidently spent some time at Rouen, perforce sight-seeing. A card from Miss Kiddle, Sister Clinical, saying, "We are idle, quite against our will as you can guess. There are 200 nurses in the town. No. 3 have begun work. No. 5 begin under canvas on the race course. Miss Jolley (Matron, Royal Southern Hospital, Liverpool) is here, also Nurses Strange, Nunn, Carter, Campbell, and Cheetham." Another card from Miss Kiddle, received September 7th, says, "We have arrived at ——; not expected. Nothing ready after 36 hours'

railway journey. Sitting on station platform at present. All keep well." No. 4, General Hospital, etc., is address of our second party.

Miss Finnis (with No. 1) writes she has met Miss Lyms, one time Sister Mary. Also, "it is very hot and trying weather here. Please excuse pencil; I am without ink, as my box and I have not met for the last fortnight."

The Matron will be glad of news from and of all Guy's Nurses at home and abroad in connection with the war.

The House-Committee and the Residents.

EXTRACT FROM THE MINUTES OF THE HOUSE-COMMITTEE, SEPTEMBER 3rd, 1914.

On the invitation of the Superintendent a large number of House-Officers attended the Committee, and the Chairman conveyed to them, and through Mr. Evans, President of the Residents, to those who were unable to attend, the hearty thanks of the Governors for the willing services they had rendered the Hospital since war was declared, and their appreciation of the loyal manner in which they had stayed at their posts in sufficient numbers to allow the work of the Institution to be carried on with due efficiency under difficult circumstances.

A similar message was to be conveyed by the Matron to the Nursing Staff, and by the Superintendent to the other Departments.

Appointments.

Royal Army Medical Corps.

The undermentioned Captain to be Major (dated September 1st, 1914):

Herbert V. Bagshawe.

The following are granted temporary rank of Lieutenant:—

E. Billing.
H. P. Costobadie.
S. S. Crosse.
A. J. Eagleton.
W. K. Fry.
H. L. S. Griffiths.
C. E. Hibbard.
F. A. Hampton.
H. C. Lucey.
F. A. Osborn.
H. A. Pallant.
R. D. Passey.
M. Pern.
W. R. Pryn.
J. T. G. Richards.
M. Scott.
C. Sherris.
Wilberforce Smith.
V. F. Soothill.
J. L. Stewart.
Arthur Tilbury.
A. D. Vernon Taylor.
B. H. Wedd.
C. Weller.
O. R. L. Wilson.

The following is granted temporary rank as Captain whilst serving with the Australian Field Hospital:—

R. Reynell.

R.A.M.C. (Special Reserve).

To be Lieutenants:—

F. Cook.
J. L. Perceval.
S. Wickenden.

Royal Navy

Temporary Surgeons:—

J. R. Barrow-Clough ... Armed Liner, *Caronia*.
G. Hamilton H.M.S. *Victory*, R.N. Barracks.
A. H. Harkness ... ... H.M.S. *Europa*.
H. C. Mann ... ... —
A. J. McNair ... ... Hospital Ship.
E. G. Schlesinger ... R.N. Depôt, Deal.

O. G. Morgan is serving with a private hospital at Namur.

C. F. Pedley is with the British Field Hospital in Belgium.

Casualties.

Wounded—Capt. Malcom Leckie, R.A.M.C.

Missing—Capt. G. H. Rees, R.A.M.C.

Lieut. M. K. Nelson, R.A.M.C. (Special Reserve).

Civil.

C. Shaw Bond, M.B., B.C., M.R.C.S., L.R.C.P., has been appointed Medical Officer and Public Vaccinator for the Bramshott (Hampshire) District.

Change of Surname.

Mr. E. Kopelowitz has relinquished and abandoned the use of his said surname "Kopelowitz," and does hereby give notice that he has assumed and intends henceforth upon all occasions and at times to sign and use and be called and known by the surname of Kerby.

PAPERS, ETC., RECEIVED.—Nursing Times, Hospital, Polyclinic, St. Thomas's Hospital Gazette, Prescriber, St. George's Hospital Journal, Clinical Journal, St. Bartholomew's Hospital Journal, New York State Journal of Medicine.

Birth.

ALCOCK.—On August 29th, at 12, Barton Street, Gloucester, to Mr. and Mrs. Arnold Alcock, a daughter.

Death.

TREWHELLA.—On August 9th, at Monart, Torquay, Henry Ellery Trewhella, M.D., aged 82.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 685.] SEPTEMBER 26, 1914. [SIXPENCE.

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Passim.

AT this time of year it is our pleasant duty to welcome the Freshman within our gates. Never before, however, in the forty odd years of the GAZETTE's life have the circumstances under which our annual sermon is delivered been as they are at present, so that we are somewhat at a loss. In previous years we could turn to the old files of GAZETTE for inspirations and suggestions on the needs of the newcomers; now, however, we do not yet know where we stand. Are we addressing the usual large October entry, or only a few who have risked the uncertainties of the future and boldly plunged into a five years' course of work.

Last year at this time we discussed at some length the prospects of medicine as a career and said that we thought they were on the whole good and distinctly better than they were a few years ago. It is impossible as yet to say with any certainty what effect the war will have in this matter as in any other, but we think it will not appreciably damage the prospects of those men who are just starting. We are, of course, confident of the ultimate result of the war and imagine that peace will shortly be followed by a wave of prosperity which will be beginning when the men now entering are finished their training and are preparing to go out into practice. Commercial prosperity always, of course, is reflected in a similar prosperity in all the professions.

We have been accustomed to urge freshmen not to bury themselves in their work to the exclusion of all else, but to cultivate the society of their fellows both in mental and physical recreations, and to urge upon them moderation both in work and in play. There have been usually the various Football and Hockey Clubs clamouring for their support in the daylight and the Debating and similar societies appealing to them at night, but this year most of the activities of the Clubs' Union are in abeyance, and so we can no longer bid them make their choice. There is, however, one body in the School which is full of activity, and which combines both physical recreation with instruction which may at any time become valuable if the War Office should need dressers for the R.A.M.C. We refer to the Officers' Training Corps, which we strongly advise every new man to join at once. The notices of the Corps will be found in the Colonnade opposite the Porter's Lodge.

We warmly welcome the newcomers and would point out to them that once they sign the register they become "Guy's men" and so become members of a large and distinguished brotherhood which is scattered all over the world, and which has nobly borne its part in the great crises of the Empire in the past and is no less nobly doing its duty in the present struggle. We hope and believe that our new colleagues will no less worthily uphold the great traditions of their School and will add yet further lustre to the name of Guy's. Let them remember that they must uphold the reputation

for honest fair-minded work and play which is the great glory of the School.

THE letters we publish in our correspondence columns, signed respectively "Old Guy's Man" and "Guyite," are symptomatic of a feeling which seems to be almost universal among Guy's men. Both our correspondents strongly criticize the action of the authorities in not providing accommodation for wounded soldiers. We were not at all surprised to receive letters about this vexed question—in truth, we had expected several more, because the action of the Governors has been condemned by almost all the Guy's men, both past and present, whom we have met during the last fortnight.

As we said in our last issue, there is no doubt but that the authorities have reason on their side when they say that their duty to the civil population is even more urgent than usual at the present moment, owing to the closing of so many beds in London usually available for the sick poor, and to the probability which exists of increased sickness during the coming winter. Their critics, however, whilst agreeing that this argument is sound, protest that it should not be pushed relentlessly to its logical conclusions. They say that the action of the hospital is very liable to be misinterpreted and that the public is much more likely to accuse the authorities of indifference than to give them credit for the very high sense of duty which prompts their action, and that, therefore, the prestige of the hospital is likely to suffer. The hospital is not yet fully endowed and must rely upon public support for its upkeep, and as a consequence will suffer in its friendly rivalry with the other London hospitals simply because it has missed this opportunity for once more bringing its name prominently to the fore.

These are the reasons urged by men out of regard for the good name and welfare of their hospital; there are other grievances of a more personal nature which are perhaps more frequently heard. It is said that the public take it for granted that a hospital, of the standing which Guy's has, is taking in wounded and that it is very uncomfortable and unpleasant for men to be continually called upon to explain and defend the conduct of the authorities in this matter. Men in practice complain that they are subjected to the sneers of fellow-practitioners whose old schools have offered beds to the War Office and otherwise made uncomfortable about it.

Of course, it is easy to reply that these are chiefly petty personal grievances unworthy of serious consideration, but most of us are, of course, slaves to the demon of "human respect," and the consciousness that perhaps the hospital is doing a better work by continuing as usual is a very poor compensation for the feeling that it and we are probably being sneered at and condemned for indifference. It is hard on Guy's men that they should not be able to feel they were actively doing their share, not in helping the State, there is no doubt on that score, but in helping the wounded, a duty which has captured the imagination of the whole medical profession.

Perhaps the decision of the Governors is not final, and it may yet be possible for them to offer beds to the War Office. They have attempted a big undertaking in trying to continue the work of the Hospital on normal lines, and have so far succeeded without great difficulty. But if the war is to continue, as seems probable, for many months yet, it may be impossible to find sufficient house-officers to look after all the beds, and so they may be compelled to close some of them. This danger would be to some extent obviated if even a small number of the beds were reserved for wounded men, as it would then be more easy to attract men to remain after they are qualified.

Whatever may happen we know that Guy's men everywhere will remain loyal to the Hospital and will support the authorities to the best of their abilities, but if the Governors can see their way to alter their decision they will immensely please all Guy's men both within and without the hospital walls.

IN common with most of the other clubs in the South of England, the Rugby and Association Football and the Hockey Clubs have cancelled

all their engagements for the coming season, and will not play unless by some happy chance peace should be concluded before the end of the winter.

The Physical, Debating and Dental Societies have not, we understand, completely sacrificed their programmes but will be content with a smaller number of meetings. In the case of the Physical Society there was a strong movement to suspend its activities till next year on the ground that it will not be adequately supported, but most of the Committee thought that it would be a pity to break the continuity of the Society's records. It was finally agreed to dispense with papers and with the annual discussion and to hold only the Clinical and Pathological evenings as these are the popular meetings.

We see with great pleasure that L. C. D. Irvine, R.N.V.R., who was on board the ill-fated "Hogue" when she was torpedoed in the North Sea, has been safely landed in Holland. He is to be congratulated in being among the fortunate few who escaped.

Papers by Guy's Men.

J. Lee Atkinson, M.R.C.S., L.R.C.P.: A Case of Rupture of the Kidney from a slight Trauma.—*British Medical Journal*, September 12th, 1914.

Charles Higgens, F.R.C.S.: Case of Recovery from Detachment of Retina.—*Lancet*, September 12th, 1914.

D. B. Lees, M.D., F.R.C.P.: The Diagnosis of Chronic Pulmonary Tuberculosis in Infancy and Childhood.—*British Medical Journal*, September 12th, 1914.

A. H. Miller, M.A., M.D.: The Cultivation of the Tubercle Bacillus: Changes in Form by Growth on Sperm Oil and Glycerine-Egg Medium.—*Lancet*, September 19th, 1914.

W. H. Shenton, M.R.C.S., L.R.C.P.: Juxta-Epiphysial Strain of the Lower End of the Humerus, and its Detection by a Diagnostic Line (with a Note on Treatment by W. H. Trethowan, F.R.C.S., M.B., B.S.).—*Lancet*, September 19th, 1914.

E. H. Starling, and another: On the Mechanical Factors which Determine the Output of the Ventricles.—*Journal of Physiology*, September 18th, 1914.

Obituary.

SIR HENRY GREENWAY HOWSE.

We greatly regret to have to announce the death of Sir Henry Greenway Howse, Consulting Surgeon to the Hospital, which took place on Tuesday, September 15th.

Sir Henry Howse, who was 73 years of age, had been Consulting Surgeon since his retirement from the active staff. He was appointed Assistant Surgeon in 1870 and Full Surgeon in 1875. He was President of the Royal College of Surgeons in 1901–3, and was knighted by King Edward VII. in 1902. He was one of the most distinguished of the old school of surgeons that have been attached to Guy's. Our generation knew him chiefly as the designer of the knee-splint which bore his name and as the pioneer in London of the then new and revolutionary doctrines preached by the late Lord Lister. We are fortunate in being able to reproduce a letter by Sir Henry Howse himself giving an account of his work with the methods of antiseptic surgery. We hope to be able to publish an account of the man and his work by one of his colleagues in our next issue.

We offer our very sincere condolences to Lady Howse in her bereavement.

JOHN TANNER,
M.A., M.D. St. And., etc.

We regret to announce the death of Dr. John Tanner which took place at Hampstead on September 8th last, at the age of 79. Dr. Tanner was at Guy's in the late fifties and qualified L.S.A. in 1860, took the M.R.C.S. in the following year, and graduated as M.D. at St. Andrews in 1862. He was successively Deputy Medical Officer at Horsemonger-lane Gaol, Assistant Physician to the Metropolitan Free Hospital, Medical Officer to the Royal South London Dispensary, and Physician to Farringdon General Dispensary and the Lying-in Charity, Holborn. He was the author of a book on practical obstetrics and of numerous papers in the medical journals. Dr. Tanner was always a prominent figure at the Biennial and other Guy's Dinners.

Correspondence.

Sir Henry Howse and Lister's Teaching.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—The death of our Consulting Surgeon, Sir Henry Greenway Howse, took place on September 15th, and his funeral on September 19th at Bromley Common Cemetery. It was attended by many of his colleagues and by Sir Watson Cheyne, President of the Royal College of Surgeons. Sir Henry was a great teacher, and for several years after he came on the full staff every dresser wished to dress for him. Sometimes every one of the dressers appointed had applied for him. His firms were excessively proud and fond of him; no one could have been kinder to them or could have taken more trouble to teach them. Crowds of students attended his Saturday afternoon clinical classes, and his firm always turned up for his Sunday morning round.

Last year a life of Lord Lister, by Dr. G. T. Wrench, was published. The author spoke of the slow progress that Lister's teaching made in London. I having in 1878–9 been Sir Henry's dresser, knew that this was not correct as far as Guy's was concerned, for he, on his appointment as Assistant Surgeon in 1870, at once went to Edinburgh, studied Lister's methods, came back, and introduced them into Guy's Hospital the same year—that is, a year before Lister's address at Plymouth in 1871. I wrote to the *Lancet* to point this out (*Lancet*, January 24th, 1914), for it seemed to me that Sir Henry's pioneer work, by which antiseptic surgery was introduced into London, ought to be known, but, of course, I first obtained his permission, and I am sure that the appended letter which he wrote to me will interest your readers. It is almost impossible for the present students to imagine the opposition which had to be overcome before antiseptic surgery obtained a wide foothold.—Yours sincerely,

W. HALE WHITE.

MY DEAR HALE WHITE,—Many thanks for your letter. I have not seen Dr. Wrench's book. My lameness makes me outside everything professional now, and I very seldom even come to London, except when it is absolutely necessary.

In 1867, when I was house-surgeon at Guy's, I began in a very small way trying the methods which were being published by Professor Lister, then of Glasgow. Naturally I did not have any very great success, but I saw enough, especially collating it with the state of our wards at that time, to convince me that there was scientific basis for his treatment of wounds, although the technique might still be exceedingly imperfect. In the Spring of 1870 I was appointed assistant-surgeon at Guy's, and resolved to spend my summer holiday in Edinburgh, mainly in Professor Lister's Wards. I am quite certain of the date, because either on my way there or back I spent a day or two at a country house with some friends in the Midlands, and while there the news of Sedan arrived, and naturally caused the greatest excitement.

In Lister's wards, the method at that time was the carbolic lac plaster, the carbolic putty, and carbolic lotion applied to the wound either with a syringe, or from a small overhead cistern, during the operation. Gauze, I think, was not used, or only very sparingly. It was, however, within a very short time made free use of. These methods I brought back with me, and introduced them at Guy's immediately.

The history of the use of the spray at Guy's is a curious one. We made use of it a very short time after my visit to Edinburgh. Two or three years previously Dr. B. W. Richardson had introduced to surgical practice a material which he called "Styptic Colloid," which was applied by spray to open wounds to arrest hæmorrhage, &c. It was tried by several of our surgeons, but in our hands it was certainly not a success. It struck me, however, that the spray apparatus might be used very effectually as a substitute to the syringe and cistern for applying carbolic lotion to the wound. I got, therefore, two or three of these sprays, and used them to our satisfaction. Within a week or two a note appeared in the medical journals saying that Lister had invented a hand-spray for the same purpose. Dr. Steele obtained one of the Listerian sprays, made by Hilliard, of Glasgow, and we found that mechanically it was more efficient than the Richardson, and so we subsequently used it. This was the form which was used for some years throughout our wards, and many generations of Guy's dressers and clerks must remember it. It was a part of the duty of the ward-clerk to "work the spray," and though it made his hands and arms ache, he usually liked the office because it enabled him to see exactly how the wound was going on. The dressers, of course, did the actual dressing during the time.

You may remember that Davies-Colley was appointed Assistant Surgeon at Guy's only a

few months after I had got my appointment. He was very much interested in my experiments in Listerism, and shortly after his appointment he came to me and told me that he was determined to carry out this plan of treatment also. Of course I welcomed his adhesion to it. I mention this because it is material to your case with Dr. Wrench that from 1871 forwards there were *two* surgeons at Guy's who were doing their best (it may be somewhat imperfectly) to carry out the tenets and teaching of Professor Lister. As far as Guy's is concerned, this ought surely to be an answer to the assertion that London surgeons were slow to avail themselves of the advantages of Listerism. It could scarcely be expected that our older colleages should readily fall in with this innovation. But with the younger Guy's Staff every Assistant Surgeon after Davies-Colley's appointment availed themselves of it. Its advantages had then become so evident that it would have been folly not to have done so.

In the evolution of aseptic surgery, or Listerism, it is necessary to remember the remarkable and *rapid* changes it has undergone in a comparatively short space of time. When I was at work in Paris in 1866, Maisonneuve used to attempt antiseptic treatment (of a kind) by his application of methylated charpie to his amputations, etc. In my observation it was not a very successful treatment, and I left Paris with a belief in our own attempts at primary union, even though they were so often unsuccessful. Amongst our own surgeons, Mr. Bryant also, by his application of iodine water to wounds, practised a kind of antiseptic treatment. I have already alluded to the evolution of the spray in 1871. The hand-spray held its ground for some time, but was then superseded by the steam-spray, a much more efficient instrument. The necessity for this has now been swept away by the much healthier conditions of our wards, and by the cleaner and more hygienic modes of operating. You know that I have been accused (and laughed at) for having held on to the spray longer than any of my colleagues. That is so, no doubt; but I should like, in defence of it, to remind you of the condition of our hospital, when we (Davies-Colley and myself) slowly and laboriously introduced Listerism, and gradually changed the aspect of our surgical wards to what they are at the present time.

In 1872, and for the two or three years following, the number of assistant surgeons, usually four, had been reduced to two, and thus it came about that Davies-Colley and myself were the only assistant-surgeons in the hospital. According to the hospital rules we had the charge of the erysipelas wards, to which all the erysipelas and severe septic cases occurring in the "general wards" were transferred as they arose. We had *sole charge* of all these cases, as well as of a certain number of beds in the general wards. In the erysipelas wards we had often to do amputations and other severe operations in beds surrounded by most highly infectious erysipelas cases, and by severe septic cases, such as gangrene and urinary extravasation. It was a *discovery*, — it was a most *remarkable phenomenon* to us, to find that we could operate on these cases in the erysipelas wards with the spray and antiseptic dressings, as safely as we could in the general wards, or even in private rooms. After this discovery, the erysipelas wards rapidly changed their character, and from being *deadly wards*, became almost like the other wards of the hospital.

The general wards themselves underwent the same change for the better. I may cite one particular case in my own experience. I took over Naaman Ward from Mr. Cock on his resignation. From the nature of his practice he had had always in it a large proportion of urinary cases (extravasation and such like —amongst the most offensive possible), and Naaman Ward bore in the hospital an exceedingly bad reputation. I was even advised not to take the ward, but (as I had the choice) to take some other. I had, however, by this time firmly established in my own mind the safety of the antiseptic treatment of wounds, and felt convinced I could make Naaman as healthy as any other ward in the hospital. This was accomplished, and many old house-surgeons and dressers must remember that I operated there as freely and successfully as in any other ward.

One word, also, in explanation and defence of my use of the spray for a considerable time after several of my colleagues had given up its use as unnecessary. While dresser and house-surgeon (about 1865 to 1867) I had become convinced that many cases became septic after operation from dressers and nurses directly infecting them, either from their fingers, clothes, or instruments. One very harrowing case of this kind, in which the patient was infected directly by the surgeon himself (of course, quite involuntarily), will remain always in my memory, and it was very largely the remem-

brance of this case, which determined me, when appointed assistant surgeon in 1870, to seek a remedy for it. Now on taking over our wards, we found every case we freshly operated on surrounded by cases foul and septic. Our dressings then had to combat this state of affairs, and we found that the hand and steam sprays which caused a cloud of 1 to 40 carbolic lotion to diffuse itself everywhere settling on *and wetting* wound, dressings, dressers' fingers and instruments and their clothes, nurses' fingers and instruments *and their clothes*, diminished the chance of infection from these sources more than any other method could have done. It was not quite pleasant to all concerned, no doubt,—but grave failures in hygiene in large hospital wards require stringent remedies. And I feel bound to say, that almost without exception, all concerned took their share in the unpleasantness bravely and with very little grumbling. I feel sure then that we owe to the sprays the rapid transformation which our wards underwent to healthier conditions. Later on, the sterilization of dressings, of towels, of instruments, and of the clothes of the surrounding Staff rendered the spray unnecessary.

I must, however, continue to think that no other method would have been so rapidly effectual *in the condition of things then existing*. Naturally, then, having seen the great change for the better from a most deplorable condition, I may have been somewhat slow in giving it up, feeling still somewhat uncertain in my mind whether the great change for the better was *permanent*, or whether the evil conditions might not recur.

With very kind remembrances and regards,—Yours very sincerely,

HENRY G. HOWSE.

The Tower House,
Cudham, near Sevenoaks,
December 27th, 1913.

The Distress in Belgium.

DEAR SIR,—In a letter I have received from a friend who is taking a great interest in the relief of the destitute in Belgium he paints an appalling picture of the utter devastation of the country. Dr. Morgan who, as you know, recently returned from a tour through a large part of the invaded area, has also told a similar story of enormous destruction of property. The helpless refugees are collected in large numbers at the sea-coast towns of Knocke, Heyst, Ostend, and Blankenburg. Many of them are totally destitute, and will almost inevitably suffer great hardships during the coming winter. They especially need warm clothing. If there are any of your readers who can spare warm clothes of any description I will forward them to the Belgian Relief Committee. Parcels should be left in the Front Lodge and marked "Belgian Distress."—Yours faithfully,

J. G. SANER.

The Hospital and the Wounded.

DEAR SIR,—The world is beginning to wonder, not unnaturally, why there has been no admission of wounded into Guy's. Questions and comment are becoming frequent and uncomfortable. The necessity for maintaining efficient service for the civil population is, of course, obvious, but in an institution which takes in so many non-urgent cases for both surgical and medical treatment, surely during war time provision could and should be made for war victims. Such provision becomes, in fact, a duty to the hospital itself as well as to the country. Guy's is likely to lose prestige among the other hospitals if it fails to do as they do in a national emergency. It is also a duty to the residents and dressers, and would almost certainly succeed in encouraging men to remain and serve their hospital instead of succumbing, as many must, to the strong appeal offered by the other more active, but no more patriotic, services.

That "the Borough" would appreciate the presence of wounded heroes in their midst is beyond dispute.—Yours, etc., OLD GUY'S MAN.

DEAR SIR,—I feel sure that dozens of old Guy's men are most anxious to know why the Hospital are not taking in any wounded. I am constantly being asked, "Why aren't Guy's having any wounded when most of the other big London Hospitals are taking them?"

Whilst realizing that Guy's are quietly carrying on as usual, and thereby doing yeoman service, one cannot but feel that the prestige of the Hospital must suffer. Is it fair that Guy's should not share in the "kudos" which is accruing to the other hospitals?

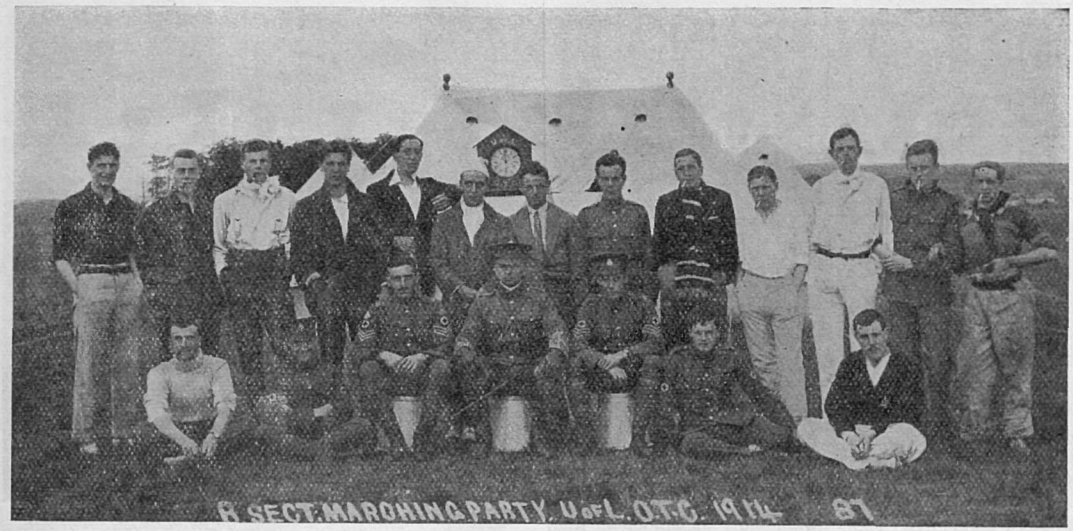
I only hope that when the Annual Accounts are looked into that there will not be a marked deficit owing to the apparent disinterestedness of those in authority.—Yours, etc., "GUYITE."

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Officers' Training Corps Camp, 1914.

THE Sixth Annual Camp was held this year at Windmill Hill, at Ludgershall, at the same place as in 1913, this site being found to be exceptionally good for training purposes, and, moreover, to give every opportunity for a useful and enjoyable camp.

The main body travelled down on Saturday, July 18th, and found the camp ready and fully equipped by the advance party, under Capt. Rutherford, which had gone down on the previous Wednesday. Everyone was pleased to hear that the medical contingent of the Edinburgh University O.T.C. was again in camp near us, and no time was lost in renewing old friendships.



A small party of 20 men of B Section, *i.e.*, from St. Thomas's and Guy's, under Capt. Layton, set out on Friday, July 17th, to march part of the way to camp. Train was taken to Basingstoke, and the party started marching from there about 5 p.m. After a march of about 9 miles a halt was made at a farm near Wolverton, where arrangements had been made for a bivouac by one of the party who had cycled on ahead. The farm was situated high up at the eastern end of the Kingsclere Downs, and everyone was very glad to be able to sleep in a barn as the night turned out very cold. An early start was made next morning in a thick drizzle and about 11 miles covered before the mid-day half, the route taking the party over the Downs and through Highclere Park, a very fine wooded estate. Another six miles or so and St. Mary Bourne was reached, where the next night was to be spent. Everyone turned in early; luckily this was the case, as it began to rain very heavily about midnight and sleep was soon out of the question as no waterproof sheets or blankets were carried. It had been intended to make an early start about 6 a.m. in order to reach camp about 12 noon, but the downpour altered the plans, and after a very hasty meal, the party started off about 3.30 a.m. Camp was reached at 9 a.m., 15 miles having been covered that morning, and just 40 miles in the whole march, which took 40 hours, a satisfactory performance under rather unpleasant conditions and at the beginning of camp.

The first few days were spent very much as usual in squad, company, and stretcher drill, varied by lectures and demonstrations of equipment. Field-days followed with instruction in the collection, carriage and care of the wounded from the firing line right back to the field hospitals, where hot meals were provided for them. Demonstrations were given in the fitting up of farm and railway wagons for the carriage of wounded on stretchers, and the extemporising of every sort of equipment for the care of injured from the most rudimentary materials. On the Saturday a long route march was carried out to Upavon and Netheravon.

Two enjoyable "smokers" were held in the Edinburghs' and our own canteen during the week. On the Sunday the contingent attended a battalion church parade at the next camp which was composed of two infantry battalions drawn from the Senior O.T.C., including the London University Infantry Contingent.

The second week was occupied by work of a more advanced character, by examinations for Certificate A and the Inter-Section Competition in stretcher drill. B Section again failed to win the cup, but there was

not much to choose between the sections. A very determined effort will have to be made when the next competition is held.

One night the contingent was moved out of camp for the purpose of practising the picking up of wounded in the dark with stretcher squads working in the new extended order, which enables a very large area of ground to be swept thoroughly by a comparatively small number of men.

On the Thursday a long field-day was carried out, working with the Infantry Battalions, and large numbers of "wounded" were treated at a dressing station and a tent division camp. Rumours of war were very much in evidence by this time, and further alarm was caused by the sudden recall to Aldershot of the Sergeant Cook and Sergeant Bugler. At the same time the work of the various advance parties of the Battalions comprising the Home Counties Division was stopped and many aeroplanes were seen flying in the direction of Aldershot.

On the Friday a staff ride was carried out, the senior cadets in parties of eight being detailed to report on the best positions for dressing stations, etc., behind a supposed firing line extending over a large front on the north of the plain, the transport and accommodation available at the various farms, and the best routes for evacuation to a supposed railhead. This scheme gave the men a thorough idea of the work of a medical officer attached to a battalion in the field. While this was being done the greater part of camp was struck by those left behind, and next morning the work was completed and the equipment returned to stores, the contingent entraining early for return to town.

We were very lucky in finishing the whole of our training, as all camps were broken up on the following Monday when the general mobilisation was started. The camp was a great success, and thoroughly enjoyable, notwithstanding the fact that the weather was hardly as good as usual, although it was never bad enough to cause very much inconvenience or discomfort. The cooking was carried out again this year very satisfactorily by our own men under a sergeant cook from Aldershot, and the canteen again run by our own Quartermaster. The transport was excellently managed as last year by men and horses from a battery of the R.F.A. from Bulford, and the chance of riding and proper instruction therein was again much appreciated.

B SECTION, WINDMILL HILL.

THE PRESENT WORK OF THE OFFICERS' TRAINING CORPS.

The advent of war has naturally made a great difference to the work of the O.T.C. The corps cannot be mobilised for service as a unit, but, as its name implies, is used for the training of men as officers to fill vacancies in the various branches of the service. In the ordinary course of events recruit drills and training would not start until after the beginning of the Winter Session, but directly the war started it was decided by the authorities to "mobilise" the corps as far as it was possible to do so and train as many new men as should take advantage of the opportunity in the work of the R.A.M.C. as a preliminary to such men taking commissions or posts as dressers. The recruiting has been very satisfactory, but it is hoped

that many more men will now join the O.T.C. when the session starts and take full advantage of the training it offers. Examinations are to be held for Certificates A and B. The advantages obtained by the possession of these certificates should be realised by all who are intending to apply for commissions in any unit of the R.A.M.C. or take up any other branch of medical work in the service.

So far the altered programme of work has been, roughly, as follows:—Drills and lectures have been held daily at all the section headquarters, and with these have been combined practical demonstrations of equipment and field work of every kind. Week-end camps are now being held for the purpose of more thorough instruction than can be given in such cramped surroundings as, for instance, our own Park. Drills are held daily at 9.25 and lectures at 4.30. Col. James has been good enough to come down twice a week, on Mondays and Thursdays, to give us lectures.

For the first three or four weeks practical demonstrations were held on Wednesday and Saturday afternoons in the Park. These included instruction in putting up and equipping dressing stations and tent division camps, field cooking, and sanitation, etc. The cooking of a hot meal for about 36 men was very successful for a first attempt, and everyone was satisfied, except, perhaps, the Warden of the College, whose windows are said to have suffered somewhat when the remains of the meal were distributed to a large crowd of Borough children outside the railings. On another occasion the men assembled at St. Thomas's Hospital, and the section was marched down to Nine Elms Goods Yard, where Col. James gave a demonstration of the fitting up of an ordinary railway covered goods van for the carriage of wounded on stretchers, a very necessary knowledge for a medical officer to have in a country like ours where very few equipped hospital trains are available.

Three week-end camps have now been held at Barnet, and these are to be continued for some time yet. The contingent assembles at the camping ground at 5 p.m. on Friday and is dismissed at 5 p.m. on Sunday, each section taking it in turn to send down a small advance party and to supply duties for the camp. Instruction has thus been given much more fully than is possible at the hospitals. The work consists of all varieties of stretcher and wagon drill in closed and extended order, both in daylight and in the dark. Dressing stations and tent division camps have been pitched and fully equipped, and the work approximated as far as possible to service conditions. On one occasion the men were surprised at 2 a.m. for a route march of about four hours and made to carry out the work of a field ambulance immediately on returning to camp. No tents are provided at these week-end camps, but men manage to make themselves comfortable for the night with extemporised bivouacs of waterproof sheets and blankets.

By this short account it is hoped that men will see that they can soon pick up a good working knowledge of R.A.M.C. work if they give up a little time to it, and it is hoped that many more will take advantage of this opportunity for training before taking commissions or appointments as dressers.

Beit Memorial Fellowships for Medical Research.

NOTICE is hereby given that the Sixth Election of Fellows will take place on or before 1st January, 1915. Applications must be received on or before the 15th October, 1914. Forms of application and all information may be obtained by letter only addressed to

THE HONORARY SECRETARY,
Beit Memorial Fellowships for Medical Research,
35, Clarges Street,
Piccadilly,
London, W.

Of Patriotism.

AMID the dust and clamour of the last few days I have been sometimes led to ask myself for a definition, for something that will tell me as near as may be what is the nature of this patriotism which is sweeping the country like a devastating wave. For the life of me I cannot tell. But of one thing I am certain that we are manufacturing patriots with a hot-house rapidity, and it is the very precociousness of their growth which makes me tremble lest the qualities which went to the making of a nation of shopkeepers should have been replaced by the elusive glimmering of an ideal. "Never," said Walter Patri, in a famous passage, "never let your principles descend to the level of your practice," but on the face of things, it seems as if we shall need to hitch up our principles to the heightening nobility of our deeds. From a people profoundly and proudly apathetic to all matters of foreign policy or imperial defence we have suddenly become a nation ready to the last man to lay down our life's blood in the struggle of "humanity," as surely as ever the Teuton hordes are dying in their thousands in the defence of "culture." Everywhere there are patriots—"a hundred thousand," we exclaimed when we read the first of the "King and Country" placards, and mindful of the Territorial fiasco—added "We shall never do it." Miracle of miracles, to that hundren thousand another was added, and yet a third is almost complete. Our supply of heroes is seemingly inexhaustible.

And after my first admiration for these men, poor, most of them, who had been neglected, underpaid, overworked, by the very country for whose service they were now asked to lay down their lives, I wondered for long at the causes which should make them willing to suffer untold hardships, to risk disablement and destitution for an end so nebulous. A complex civilisation collects around itself parasites of all descriptions, those who gratify its appetites, those who pander to its pride and self-sufficiency, those who trade upon its stupidity and brutality. In a less evolved society these parasites have not yet risen to existence; on a return to a simpler state they are absorbed into its corporate life.

A national crisis of any kind, be it war, pestilence, or famine, will result to a greater or less degree in this absorption, and it is when the popular conscience is dead or sleeping that they most multiply and flourish. And so to-day—I said to myself—when as a nation we are passing through a period of the gravest peril, we shall find that those we were wont to regard as the drones and vampires of the State have been caught and drawn along in the onrush of our national awakening. And filled with this idea I thought to see no more the the loungers in Piccadilly, the all-day golfers, the men about town, the cab-touts, the paper boys, the theatrical hangers-on; all the scum which a great city collects and of whom in time of peace it cannot rid itself. But I found I was wrong. The appearance of Piccadilly was as before, the round of pleasure was apparently unchanged. The people whom I had assumed would form such an army as we needed were blandly continuing their life of parasitism. In fact, the personnel of "Kitchener's Army" was being recruited from the very classes who in peace perform all the dangerous and disagreeable jobs of the community. A sort of moral press gang was, and is still, at work; young men were dismissed by their employers who told them plainly that unless they enlisted there would be no chance of re-engagement. In the North, where the mills are on half-time, no man of an age to serve will get employment if he fails to do so. Big employers of labour, one reads every day, hold meetings of all their hands, and after being harangued, and one can guess the nature of the exhortation, several hundreds at once rush to the nearest recruiting station. Young women (according to the picture press) offer white feathers to any young man they see not in uniform. A sort of wild hysteria has passed over those who are exempted either by age or sex from making any effort to aid their country. Paunchy company directors and impressionable females are magnificent in their efforts to persuade other people to do their duty for them. All who enlist, even under suasion, are to be heroes; all who do not are, without discrimination, to be cowards. It seems to me that those who for one reason or another have hitherto failed to enlist will find it hard to do so, for if they do so through fear of public opinion they will be guilty of the very vice they are told to avoid—cowardice. Let us have one thing or the other, conscription or free impulse, but do not let us be worse than barbarians, and use the bludgeon with one hand and soft soap and cant with the other. While retaining the pretence of a voluntary system we seem to have adopted an excellently organized scheme of moral compulsion. And apart from those who are herded in to fight for moral reasons, there is, I am sure, a great deal of needless misery caused by the thoughtless rush to arms of those whose duty lies plain in the more humdrum spheres of life. Little is served by those who unthinkingly enlist to leave want and misery in their homes and who return, wrecked and crippled, to be a burden to their friends and the State. A poor woman told me in tears the other day of her husband who had gone to enlist leaving her and her four helpless children utterly unprovided for. Her case is one of thousands. Heaven knows one does not wish to belittle the courage of men who have volunteered to lay down their lives for their country, but one cannot help suspecting that for recruiting purposes a brass band and a good send-off is a great deal more effective than the plea of humanity and justice. It is as well, I doubt not, to take this inhuman business with as light a heart as we can, but there is always the danger that in yielding to the thrill and glamour of a call to arms we shall leave neglected those essential tasks which carry with them no glory and whose fulfilment is their only reward. It is often easy to die for a cause, to live for one is harder.

G. H. F. G.

The Treatment of the Imperfectly Descended Testicle.

CLINICAL LECTURE BY PHILIP TURNER, M.S.

GENTLEMEN,—The subject which I have chosen for to-day's lecture is for several reasons of considerable importance. It is a serious deformity, especially when, as is frequently the case, the trouble is bilateral; it is a bar to entry to the public services, and in these days when owing to the workmen's compensation act, most large companies and firms insist on a medical examination of their employees, it is a serious hindrance to the patient obtaining employment in many other walks of life. The present methods of treatment, too, at any rate of conservative treatment, can only be described as highly unsatisfactory. The chief object of this lecture is to bring to your notice a method of conservative treatment which I have employed in a number of cases during the past year, and which I think gives very much better results than the usual operations for replacement of the imperfectly descended testicle in the scrotum.

It will first be necessary to remind you that the testicle is developed within the abdominal cavity from the genital ridge, which is situated to the inner side of the wolffian body. It is subsequently, by the action of the gubernaculum, drawn downwards passing along the inguinal canal into the scrotum, a process of peritoneum accompanying it which becomes the tunica vaginalis, and which at first communicates with the general peritoneal cavity by means of the processus vaginalis. The descent of the testicle should be complete by the time of birth, though occasionally the normal descent is only completed after a further interval of a few weeks or months. The testicle may be arrested at any point in its descent. Thus it may not leave the abdominal cavity, or it may enter but not emerge from the inguinal canal, or it may reach a point just below the external abdominal ring. In some instances the testicle emerges from the inguinal canal, but does not arrive in the scrotum. Thus it may pass beyond the scrotum into the perineum, or it may reach the front of the pubes close to the root of the penis, or it may pass downwards from the external ring into Scarpa's triangle, or upwards and outwards towards the anterior superior spine of the ilium. When in one of these situations the condition is regarded as one of misplaced testicle rather than an imperfectly descended organ, but no sharp distinction can be made between the two, and I am sure that at any rate in many cases the misplaced organ could be treated in the same way as that described below for imperfect descent.

We must now consider certain important points with regard to the anatomy of the imperfectly descended organ. The first is that in the great majority of cases that the processus vaginalis remains patent so that there will be an accompanying congenital hernia or hydrocele. Even in cases where no hernia can be detected by ordinary clinical examination it is extremely probable that a patent processus vaginalis will be found at the operation. There will also be a well-marked mesorchium so that the testicle and epididymis hang freely in the cavity of the tunica vaginalis, suspended by a mesentery like fold of the serous membrane. Remains of the gubernaculum will be found extending downwards from the lower pole of the testicle to become lost in the soft tissues of the groin or of the scrotum; often this will appear as a very thick and well developed fibrous band. Though the testicle may not emerge from the external abdominal ring, it is very common to find that the tunica vaginalis extends along the gubernaculum to a much lower level. The testicle itself is practically always small and badly developed. Indeed it may be so small as to be scarcely palpable. As an example of this I have recently operated on a case where the testicles could not be felt, and it was assumed that the organs could not have left the abdominal cavity. At the operation, however, it was found that a small and ill-developed testicle was present in the inguinal canal.

We have now to consider a very important point, whether the imperfectly descended organ is or is not functional, for obviously this has an important bearing on the desirability of conservative treatment. It may first of all be stated that even when both testicles are imperfectly descended and are ill-developed that the individual will be perfectly virile, and that all the secondary male characters—voice, hair, and general appearance—will be normally developed.

It may, therefore, be taken for granted that one of the functions of the testicle—that of producing an internal secretion—is carried out by the imperfectly descended organ. With regard to the other function, that of producing normal spermatozoa, there is no doubt that the retained

testicle in the majority of cases is functionless. This can readily be proved by the histological examination of organs which have been removed. On the other hand, it is undoubtedly the case that in some adults, even when both testicles have never descended into the scrotum, normal active spermatozoa are produced, and such individuals are by no means always sterile.

It has been maintained that all imperfectly descended testicles are functionless, at any rate as regards the formation of active spermatozoa, and that even if successfully replaced in the scrotum before puberty they are incapable of normal development. The cases mentioned above are certainly against this view, and I cannot help thinking that if the testicles are transplanted to the scrotum some time before puberty—say between the ages of five and ten years—that there is at any rate a good chance that the organs may become functional, provided that the transplantation can be carried out without seriously affecting the blood supply or damaging the testicular substance. Even in adults there is a possibility that the retained testicle is functional, and apart from this most men would prefer to have the malposition rectified to having the organ excised.

If an undescended testicle be exposed in the inguinal canal in the course of an operation and an attempt be made to replace it in the scrotum before any of the component parts of the spermatic cord or its coverings are divided, it will be found that certain of these structures become tense and prevent any further advance of the testicle long before the bottom of the scrotum is reached, and directly traction is stopped the testicle retracts to its original position. What are these structures which prevent transplantation of the testicle? First of all there is the hernial sac, or when there is no hernia, the patent processus vaginalis which we have seen is practically always present. Next there are the fascial coverings of the spermatic cord, the infundibuliform, cremasteric, and intercolumnar fasciæ. Then the descent of the testicle is also hindered by the attachment of the remains of the gubernaculum. We have seen that this is very often a strong fibrous band, and when the testicle is undescended the remains of the gubernaculum will probably blend with the soft tissues of the groin, in front of the pubis, or in Scarpa's triangle. When the attempt is made to push the testicle into the scrotum these bands become tense and prevent its advance. Any shortness of the vas is very unusual, but sometimes the vessels of the spermatic cord become decidedly tense when the testicle is forced down into the scrotum. The question of the vessels is one of great importance, for if in the course of the operation these are divided atrophy of the already imperfectly developed organ may be certainly expected. Thus in any operation for transplantation of the testicle the hernial sac must be removed, the fasciæ completely divided, and the gubernaculum cut across, while the vas and the vessels should be carefully preserved from injury.

Another extremely important anatomical hindrance to the satisfactory transfer of the testicle is the imperfect development of the scrotum. If the trouble is unilateral the side of the scrotum which contains the normal testicle will probably be well developed while the opposite side may be almost non-existent. In such cases the median septum of the scrotum may be almost horizontal. When both testicles are undescended the scrotum may be merely represented by a patch of corrugated skin.

Before dealing with the actual operations it will be best to briefly mention some of the reasons for operating on these cases apart from the deformity and the question of function.

1. The co-existence of a hernia. This is a strong indication for operation.

2. There is a possibility of torsion of the spermatic cord and subsequent gangrene of the testicle. The increased liability of an undescended testicle to torsion is explained by the presence of the mesorchium.

3. The undescended testicle is extremely liable to become inflamed. This may be due to injury. Although the normal testicle is apparently very exposed to injury, yet in reality owing to its extreme mobility this is not so. The undescended testicle on the other hand is not nearly so mobile and its position in the groin renders it extremely liable to receive blows and also slighter injuries in the ordinary action of the muscles in walking, etc. Acute inflammation may occur secondary to mumps and some other infective diseases, and acute epididymo-orchitis may follow an attack of gonorrhœa. As an instance of the latter I will mention a case that I saw in the medical wards some ten years ago when I was medical registrar. A male patient had been admitted for acute appendicitis and all his signs and symptoms were characteristic of that disease. However, on going over him I found that the right testicle was not in the scrotum and could not be felt at all. The man, who was about twenty-five years

old, said that there had never been any sign of it. Further enquiry elicited the fact that he had an attack of gonorrhœa about a month before, and that even then there was a slight gleety discharge. I have no doubt that this was a case of acute epididymo-orchitis in an undescended testicle, and that the tender lump in the right iliac fossa was the inflamed organ. Unfortunately, cases of appendicitis were not in those days operated upon with the frequency that they are at present, and as the inflammation subsided the diagnosis was not verified at an operation.

4. An undescended testicle is said to be more likely to become the site of malignant disease than a normally placed organ. Though there are specimens of this combination in every museum the statement cannot be regarded as certainly proved.

It will thus be seen that a patient with undescended testicles runs a good many risks and that the condition should always be treated. The following methods are possible:—

1. Mechanical treatment by a "horse-shoe" truss. This is not likely to be successful and will not be further mentioned.

2. Excision of the testicle. This is, of course, only admissible when the other testicle is normally situated and developed. In favour of excision, it is argued that the undescended organ is ill-developed and probably functionless, and that an excision is preferable to an unsuccessful attempt at transplantation to the scrotum.

3. The undescended testicle may be pushed up into the abdomen and the inguinal canal sutured. This may be indicated when the descent of both testicles has been arrested and, owing to shortness of the vas and vessels, transplantation to the scrotum cannot be effected. It is also indicated when an attempt to fix the opposite testicle in the scrotum has failed, or when the opposite organ has been excised.

4. The undescended testicle may be transplanted to the scrotum. A consideration of the facts above mentioned will show that this is the most desirable method of treatment when the deformity is bilateral, especially in children, if it can be satisfactorily accomplished without undue injury to the substance of the testicle or interference with its blood supply. Even in adults where only one testicle is retained the organ may be functional, and most men would certainly prefer a transplantation to an excision if the former will give a reasonable prospect of freedom from injury and traumatic inflammation.

The usual operation for fixing the undescended testis in the scrotum, or orchitopexy, is usually carried out on the following lines. An oblique incision is made in the groin with the external abdominal ring as its centre. The intercolumnar fascia and the external ring are divided and the inguinal canal opened up. The testicle, enclosed in its tunica vaginalis and the spermatic cord are then identified. The hernial sac is completely removed; the cut end of the processus vaginalis immediately above the testicle may be ligatured to close the tunica vaginalis. All fasciæ, bands of gubernaculum, etc., which hinder the testicle from entering the scrotum are divided, some of the veins of the spermatic cord may also require division, but it must be remembered that if the blood supply is much interfered with, that atrophy of the testicle is certain. A bed is now made for the testicle in the scrotum with the finger and the testis pushed down to its new position. Usually directly traction is relaxed the testicle, by the elastic action of the spermatic cord, is at once again drawn up into the groin. Hence sutures are necessary; these are passed through the substance of the testicle so as to secure a hold of the tunica albuginea and then deeply into the soft tissues of the bed of the scrotum. Even now the tendency of the testicle to rise will very likely actually invaginate the scrotum. To overcome this various plans have been adopted. The sutures transfixing the testicle may be made to pass through the skin of the scrotum and are tied over a small roll of gauze; or the sutures, after passing through the skin of the scrotum are fixed to the skin on the inner side of the thigh, or to a wire cage fixed over the scrotum or to the opposite thigh. In spite of these precautions the results of the operations are most unsatisfactory.

The testicle practically always atrophies or again resumes its former position. When the fixation stitches have been removed or have cut through, there is no force that can be exerted to counterbalance the elastic action of the spermatic cord, and later on the contraction of the fibrous tissue which is necessarily formed. Digital traction, even when frequently and regularly applied, is not effective, and hence, even when a good result appears probable after a few weeks, the ultimate result, after an interval of some months, is almost uniformly bad. The reasons for the bad results of this operation are as follows:—1. The absence of any continuous natural force tending to hold the testicle in its new position. 2. The excessive

damage to the testicle by the passage of sutures and by the inflammation which is almost certain to follow must greatly increase the tendency to atrophy. 3. In the effort to relieve all tension, damage to the vessels and bruising of the vas are only too likely to result. 4. It is extremely probable that the scrotum on the affected side is so badly developed that there is not sufficient room to make a satisfactory bed for the testicle. If this is so, it is hopeless to expect the transplantation to be successful.

The operation that I am about to describe to you aims at overcoming these difficulties by transplanting the undescended testis to the opposite side of the scrotum. If, for instance, the right testis is in the inguinal canal, the right side of the scrotum, which has never enclosed the testicle, will be small and ill-developed.

The left side of the scrotum, on the other hand, which contains a normally developed and situated testis, will be well developed and better able to contain the right testis than the ill-developed right side of the scrotum. The misplaced organ is transplanted through a small opening in the septum of the scrotum, passing, of course, beneath the urethra. No fixation sutures are required, as the small hole in the elastic septum quickly contracts after the testicle has been drawn through. Again, any attempts to resume its former position are counteracted by the weight of the scrotum acting through the septum continually exerting gentle traction. This gentle continuous force tending to keep the testicle in position is entirely absent in the ordinary operation of orchitopexy. When the trouble is bilateral two operations are necessary. At the first one of the undescended testicles (say the right) is transplanted to the opposite side of the scrotum (the left). After an interval of two or three months, if the result of the first operation is satisfactory, that is if the testicle remains in the scrotum and has not diminished in size, the opposite testicle (the left) is transferred to the other (right) side of the scrotum.

The following is a more detailed account of the operation. An oblique incision is made through the skin and fasciæ, extending upwards and outwards above and parallel to Poupart's ligament. The external oblique having been thus exposed a short incision is made in its aponeurosis commencing just external to the external abdominal ring and extending upwards and outwards; the ring itself is not divided. The internal oblique thus exposed is drawn upwards by a small retractor.

A little dissection will then enable the testicle enclosed in its tunica vaginalis, and the spermatic cord and the processus vaginalis to be brought into the wound. The remains of the gubernaculum attached to the lower pole of the testicle will also become obvious. By means of a blunt dissector the fascial coverings of the cord are torn through longitudinally, and the hernial sac is separated from the vas and the veins. The sac having been localised, it is separated right up to the internal ring where it is transfixed and ligatured. It may also be ligatured below where it joins the tunica vaginalis, and then having been again divided above the ligature, is removed, the opening into the tunica vaginalis being closed by the ligature.

The testicle is now gently pulled on, and all fascial and fibrous bands which become tense are divided between ligatures so as to avoid hæmorrhage. During these proceedings the vas and the vessels must be treated with every care. In some cases a few veins may require division, but any serious interference with the blood supply will greatly increase the liability to atrophy. As the result of these steps the testicle will be much more mobile, and can probably be drawn with ease below the level of the external ring. The testicle is now drawn upwards, and in this way the fibrous remains of the gubernaculum are put on the stretch. This fibrous band is now transfixed by a needle threaded with strong catgut a short distance below the lower pole of the testis.

In doing this care must be taken to avoid injury to the vas and the epididymis which sometimes extend for some distance below the testicle itself. The fibrous band is then divided below the ligature. The testicle is now only connected by the vas and veins, while the divided gubernaculum is secured by the ligature, the ends of which are left long. The whole wound is now covered with a sponge soaked in hot saline, and a second incision about an inch in length is made in the opposite side of the scrotum in front of the normally placed testicle on that side. The cellular tissue between the normal testicle and the septum of the scrotum is now opened up and a bed made in this situation with the finger or blunt dissector. The tunica vaginalis is, of course, not opened. The free ends of the ligature are now seized with Spencer Wells' forceps which are passed through the incision in the external oblique, then forced through the external ring down into the scrotum; if a finger of the other hand be introduced into

the second wound the end of the forceps may be felt after a little manipulation forced against the scrotal septum. A small incision is made against the end of the forceps which now are pushed through the septum into the second wound. The ends of the ligatures are then seized and the forceps withdrawn: by forcibly opening them the track can, if thought necessary, be enlarged. The ends of the ligatures are now pulled upon and in this way the undescended testis is carefully drawn along the track which has been prepared for it through the opening in the septum to the opposite side of the scrotum.

Directly the testicle has passed through this opening the elastic fibrous and muscular tissues of the septum contract and prevent it slipping back. No sutures are therefore required to fix the transplanted organ in its new position. Both wounds are washed out with saline. The second wound only requires a few stitches for the skin, but the first requires also a continuous suture of fine catgut to close the incision in the external oblique. If the deformity is bilateral one of the testicles is transplanted to the opposite side of the scrotum in the way described above, and then after an interval of about three months during which the patient is kept under observation to make sure that there is no atrophy and that the transplanted organ remains in position, a similar operation is performed for the testicle of the opposite side. The most desirable age for the operation is probably somewhere between five and ten years. If the testicle has not reached the scrotum by this time it is extremely improbable that it will ever do so, and at this age there is hope that the transplanted organ may subsequently undergo its normal development. Even in adults I should perform this operation rather than excision unless there should be some special indication for the latter.

As regards results I have only performed this operation during the last year, and so have not been able to watch any cases for a long period. So far, however, all have been most encouraging. There is no doubt that the testicle remains in the scrotum; I have not yet had a case in which it has returned to its old position. As regards atrophy, it is, of course, impossible to speak, but in two cases the testicle has undoubtedly increased in size. There have been no cases of orchitis or attacks of pain, and in no case has an excision of the testicle been subsequently called for.

Pass List.

Society of Apothecaries of London.

The following candidates have been approved in the subjects indicated :—

Surgery (both parts).

C. de W. Gibb. C. R. Smith.
A. N. Minns. R. J. Hearn.
W. M. Lansdale.

Medicine.

*†C. de W. Gibb. *†C. R. Smith.
*†A. N. Minns. †R. J. Hearn.
*†W. M. Lansdale.

Forensic Medicine.

W. M. Lansdale. A. N. Minns.
C. de W. Gibb. C. R. Smith.

Midwifery.

C. de W. Gibb. A. N. Minns.
C. R. Smith. W. M. Lansdale.

* Section I. † Section II.

The diploma of the Society has been granted to Messrs. R. J. Hearn, C. de W. Gibb, A. N. Minns, C. R. Smith, W. M. Lansdale.

Conjoint Examination.

At the Special Examination in Practical Pharmacy held on September 10th, the following candidates were approved :—

F. Bocquet Bull. G. S. B. Long.
G. W. King.

Nursing News.

Matron's Office.

Misses H. M. Vine (late Sister Charity and Housekeeping Sister), K. Vine, F. L. Davies, B. Martin, K. Bishop, M. Foord-Kelcey, left London on the 24th September with orders from the War Office to report themselves at Southampton. Miss Surtees left for Winchester earlier in the week also for War Office service.

The Dental Society.

There will be a General Meeting of the Dental Society in the Anatomical Theatre, on Wednesday, 30th September, at 12.30 p.m., to discuss the day and hour of the monthly meetings. It is hoped that all interested in the Society will endeavour to be present.

Guy's Hospital, 21st Sept., 1914. W. J. ROUSSEAU VILJOEN, Hon. Sec.

Lectures* for Sessions 1914—1915.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Fagge and Mr. Rowlands	9	—	Tu	W	Th	—	—
Microscopical Pathology (3rd) ...	Dr. Laidlaw and Dr. Eyre	2.30	—	—	W	Th(10)	—	—
Pathological Classes (3rd & 4th)	Dr. Laidlaw and Dr. Goodhart ...	—	—		W(11.30)	Th(9.15)	Sat(11)	
Bacteriology (Jan. to Mar.) (4th)	Dr. Eyre and Dr. Lucey	4	—	Tu	—	—	—	—
Practical Obstetrics (3rd & 4th)	Mr. McNair (Oct. and Jan.)	11.30	—	—	—	Th	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Mr. Ryffel & Mr. Marshall	11	—	—	—	—	Fri	Sat
Chemistry (1st and pre. sci.) ...	Dr. Lowry	9.30	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Lowry, Mr. Merriman and Mr. Rogerson	10.30	—	Tu	—	Th	—	—
AdvancedPracticalPhysiology(3rd)	Dr. Pembrey, Mr. Ryffel, and Mr. Marshall	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Mr. Mutch, Mr. Barber, Mr. Heaton, and Mr. Ryle	—						
Experimental Physics (pre. sci.)	Dr. Fison	3	M	Tu	—	—	—	—
Chemical Physics (1st)	Dr. Fison and Mr. Abram	11	M	—	—	—	Fri (2)	—
Practical Surgery (3rd)	Mr. Todd, Mr. Mullally, Mr. Schlesinger and Mr. Ozanne	12.30	—	Tu	—	—	Fri	—
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1.30	—	—	W	—	—	—
Surgery (3rd)	Sir Arbuthnot Lane, Mr. Dunn, Sir Alfred Fripp and Mr. Steward	9.30	M	—	—	—	Fri	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Mr. Evans and Mr. Reed	10.45	—	—	W	Th(2)	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. French, Dr. Cameron and Dr. Hunt	2	M	Tu	W	Th	Fri	Sat(12)
Medicine (3rd)	Dr. Hale White, Dr. Shaw, Dr. Fawcett and Dr. Beddard	4	—	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Eason	4	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. King Brown	4	M	—	—	—	Fri	—
Anæsthetics	Mr. Rowell (Dec.)	—						
Dental Surgery and Pathology...	Mr. Wynne Rouw	4	—	—	—	Th	—	—
Metallurgy	Dr. Lowry...	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Pearce (Jan.)...	2.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Hopson	4.15	—	—	W	—	—	—
Dental Mechanics	Mr. Lewin Payne (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—
Pathology	Dr. Laidlaw	12.30	—	—	—	Th	Fri	—

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.					
Medical Jurisprudence (3rd & 4th)	Mr. Ryffel	10	—	—	W	—	Fri	—
Midwifery (3rd)	Mr. Bellingham Smith and Mr. Chapple	9	—	Tu	W	Th	—	—
Diseases of Women	Mr. Bellingham Smith and Mr. Chapple	9	—	—	—	—	Fri	—
Mental Diseases (3rd)	Dr. Craig	9.30	M	—	—	—	—	—
Bacteriology (April to June) (4th)	Dr. Eyre and Dr. Lucey	4	—	—	W	Th	—	—
Practical Obstetrics (3rd) ...	Mr. McNair	11.30	—	—	—	Th	—	—
Biology and Botany (pre. sci.) ...	Mr. Evans and Mr. Reed	2	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey	9.30	M	—	W	—	—	Sat
Histology (1st)	Dr. Pembrey, Mr. Ryffel, and Mr. Marshall	10.30	M	—	W	—	—	Sat
Practical Surgery (3rd)	Mr. Todd, Mr. Mullally, Mr. Schlesinger and Mr. Ozanne	12.30	—	Tu	—	—	Fri	—
Practical Medicine (3rd) ...	Mr. Mutch, Mr. Barber, Mr. Heaton, and Mr. Ryle	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Dr. Fison and Mr. Abram	1.30	M	Tu	—	—	—	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.30	—	—	W	—	—	—
Morbid Anatomy (3rd & 4th) ...	Dr. French, Dr. Cameron and Dr. Hunt	2	M	Tu	W	Th	Fri	Sat(12)
Therapeutics	Dr. Beddard	4	M	Tu	—	—	Fri	—
Anæsthetics	Mr. Rowell (June)	—						
Operative Dental Surgery ...	Mr. Parfitt	2	—	Tu	—	—	—	—
Chemistry	Dr. Lowry	9.30	—	Tu	—	Th	—	—
Practical Chemistry	Mr. Merriman and Mr. Rogerson ...	10.30	—	Tu	—	Th	—	Sat(10)
Exp. Pathology (Gordon Lectures)	Dr. Laidlaw	12.30	—	—	—	—	Fri	—
Pharmacology	Dr. A. J. Clark	—						

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

Anatomy and the Dissecting Room.

The primary object of dissecting is to learn anatomy. By seeing the structures lying in their proper relations one to another a mental picture is obtained which cannot be had by reading or looking at pictures; by cleaning these structures and tracing them from above downwards their course is impressed on the mind; and by removing each muscle from its attachment those facts are learnt which have been taken for granted when first reading the bone.

In addition dissecting trains the fingers and develops the sense of touch, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is absolutely essential to buy a half skeleton and a disarticulated skull. (These may be had from Hancock, the dissecting-room porter, who will also supply apron and sleeves—price 2s. 6d.—and cases of instruments).

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

Books and Instruments.

The student must have two books of anatomy, the one to read it systematically by starting with each muscle, nerve, or other structure, the other to read it topographically as each structure is exposed in the course of dissection.

The book for the latter is Cunningham's Practical Anatomy (2 vols., 10s. 6d. each); it should be taken into the room and read before, during, and after each day's work.

The best books for the former are Gray's or Cunningham's Anatomy. Those reading for higher examinations might also get Quain's Anatomy, of which the eleventh edition is now appearing in parts. These will also need at some period a book on Embryology. The best book on this subject for students is Keith's as it is written from a surgical point of view.

The following instruments are necessary :—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are necessary, and the small forceps used in the biological department are worse than useless.

How to begin Work.

The following rules will help :—

1. Bring up an old coat, and procure an apron and sleeves. These keep you clean. Men are sometimes seen dissecting in their everyday coat, or in their shirt-sleeves without rolling them up. The cuffs and arms then get sodden in fat and body fluid, which substances are transferred in the evening to the dinner cloths of the student's parents or landlady. Such dirty habits need no comment.

2. Deposit 5s. at the Medical School Office and procure the key of a locker in which to put these and other requisites for dissection.

3. Attend at 12 noon on Thursday, October 1st, the introductory demonstration given by the Senior Anatomy Demonstrator. You will there be given a "Red Book" containing the rules of the dissecting-room, and will be told in greater detail than is possible here, the ways of the room and the work to be done.

4. In the afternoon of October 1st look for your name on one of the lists, and find out what part has been allotted you. Then find out the times of the bone and other classes which correspond to this part. They are held by Mr. Mullally, Mr. Todd, Mr. Schlesinger and Mr. Ozanne.

5. Either that afternoon or early next morning begin dissecting, and remember

(i.) Not to be in a hurry.

(ii.) To read carefully in your book (Cunningham) the pages describing the surface markings of the part, and the lines of incisions that must be made.

(iii.) To turn back *the skin only*, leaving the fat upon the body.

(iv.) To remove carefully this fat, leaving intact the white layers of "deep fascia" which cover the muscles.

(v.) To clean the surface of the muscles. Cut with the grain or muscle fibre, and clean it *right up to its attachment to the bone.*

(vi.) Always read ahead of your dissection, either in the pickle-room, or wax-model museum.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While attendance at physiology lectures and the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain

mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

During the first summer session and the first half of the second winter session the student should attend the lectures on Physiology (for times, *vide* table, p. 364), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, or Howell's *Text-book of Physiology*. While attending the practical classes held during the winter the student is advised to read *Practical Physiology* (published by Arnold).

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Text-book of Physiology*, *Recent Advances in Physiology and Bio-chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required, but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasized, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open from 9 a.m. to 5 p.m. on Mondays, Tuesdays and Wednesdays, and from 9 a.m. to 6.30 p.m. on Thursdays and Fridays, and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought, and rarely, indeed, be practical experience that is so destructive of thought, and such reading is very properly stigmatised as "cram." "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

For the coming term, Chemistry Lectures start on Tuesday, October 6th, at 9.30 a.m. (Chemical Theatre, entrance opposite Laboratory, third floor); but before this students should go to the Chemical Laboratory on Thursday, October 1st, at 10 a.m., to receive their locker keys and apparatus and commence practical work. Practical Organic and Applied Chemistry starts on Thursday, October 1st, at 2 p.m., and the Lectures on Friday, October 2nd, at 10 a.m. Physics Lectures commence on Monday, October 5th, at 3 p.m. (Class Room IV., second floor).

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription; it may even be necessary for the majority, when qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The student is taught practically the methods of prescribing, he practises writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

During the year there may be three courses of three months each, should a sufficient number of students

require instruction, which is given in the practical pharmacy class at the Dispensary by Mr. Finnemore, B.Sc. Lond., F.I.C., the Hospital Pharmacist.

MEDICAL WARDS.

The medical ward clerk should not read through a text book, but should become thoroughly acquainted with those diseases of which he finds examples in the beds which have been allotted to him. He should spend all his spare time in the medical words, observing and learning the physical signs of health and disease. If he is keen the house-physician will give him an opportunity of helping at "tappings" and venesections, and watching him examine an acute abdomen. He must have ready rough notes of the cases for the Medical Registrar, who goes round four times a week starting in the female wards at 10.15, and he must write a full report for the Physician, and after the visit of the Physician, *the ward clerk should at once enter the remarks made by the Physician and his diagnosis.* The wards are always open to the clerks after 10 a.m., except from 1 to 1.30 p.m. The reports should be brief but thorough, and when in difficulties the ward clerk will always find the Registrar and Clinical Assistants ready to assist him. No ward clerk will know anything of medicine unless he attends regularly in the post-mortem room. The books usually read here are "Taylor" and "Osler," "Clinical Methods," by Hutchinson & Rainey, or "Medical Laboratory Methods," by French.

PATHOLOGY.

As soon as a student has passed his Second Conjoint or M.B. examination, he should begin his study of pathology. Without a sound knowledge of this science it will be impossible for him to obtain any real knowledge of medicine or surgery, and he can, therefore, never be too emphatically urged to attend the autopsies on everyone of his cases, and to spend as much time as possible in the post-mortem room. Autopsies are conducted every day of the week at 2 p.m. (Saturdays at noon), by Dr. French, Dr. Cameron and Dr. Hunt. The microscopical examination of material removed by operation, is often the only means of arriving at a definite diagnosis, and it is therefore equally important that the student should obtain an adequate knowledge of microscopical appearances in disease.

Classes on microscopical pathology are held by Dr. Laidlaw and Dr. Eyre on Wednesday afternoons and Thursday mornings throughout the year. Bacteriology being taken in October to December and April to June, and morbid histology from January to March and July to September. Further the student should attend Dr. Hunt's classes on medical pathology, and Mr. Davies-Colley's on surgical pathology which are held three times a week.

In order to learn something of the principles which underlie pathology, the student should attend the lectures on general pathology. In May and October there are also informal classes adapted for the requirements of candidates for the first part of the Third M.B. Cantab., and the final M.B. of Oxford and London Universities.

The best elementary manuals are Green's "Pathology" and Adami and Macrae's "Text-book of Pathology"; Hewlett's "Pathology, General and Special" is good but hardly full enough. For general pathology read Adami's "General Pathology" and Lazarus-Barlow's "General or Experimental Pathology," and for morbid histology Grünbaum's "Essentials of Morbid Histology," or Woodhead's "Practical Pathology," of which the illustrations are very good. Many of the articles in Allbutt and Rolleston's "System of Medicine" should be consulted. For bacteriology Muir and Ritchie's "Manual of Bacteriology" is recommended.

BACTERIOLOGY.

Every Guy's man devotes at least three months to the practical study of Bacteriology. This compulsory course comes under the heading of Microscopical Pathology, and is held every Wednesday afternoon and Thursday morning from October to December, and again from April to June.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus and morbid exudates by various methods to demonstrate the associated bacteria. He estimates the amount of specific agglutinins or opsonins contained in the serum of patients under treatment in the wards. In addition, he is instructed in the practical work of media-making, culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced classes and lectures which are available during the fourth and fifth years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis which the past generation of medical men are compelled to entrust to the pathological experts of their own or other hospitals, or, as so often happens, to the various commercial houses which make a speciality of clinical research and diagnosis. Demonstrations are also given upon the life-history of the various organisms pathogenic to the human race, and the changes such organisms

undergo or produce when they gain entrance to the human tissues.

In order that the student may make the fullest possible use of his opportunities of correlating the clinical symptoms resulting from the infection of the patient's tissues by various pathogenic organisms, the class in bacteriology should be taken out as early as possible during the period of clinical study, and the work has so been planned that the whole of the six months devoted to microscopical pathology may run coincidently with the appointment of medical or surgical clinical clerk: and it should be emphasised that the clerk's absence from the wards during the hours the class is being held is not only sanctioned, but, indeed, is expected by his chiefs.

During February and March of each year a course of lectures is given dealing even more specially and technically with the applications of bacteriology to practical diagnosis and treatment, and in these the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treatment of disease are fully discussed, together with the facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that, with the assistance available at his disposal, his difficulties will be found to be anything but insurmountable.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. There is no better way of impressing the facts of a case on one's mind than is gained by the construction of a correctly detailed report, which, moreover, will be of value if the case has to be referred to at a future date. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary.

It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual application of Croft's and Bavarian splints and treatment of fractures is all too short as it is.

As soon as he is appointed, he should obtain from the Medical School office the "Notes on Surgical Case-taking" issued by it. A few days before taking over the work he will meet the surgical registrar to find out to whom he is appointed, and should then learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work. He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

He should also attend the practical surgery classes of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment, and also the course of practical pathology which is then in progress.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appoint-

ment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which usually take place on Mondays, Tuesdays, Thursdays and Fridays, except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted at the operations by the dressers, and the particular clerk to the case should remain close by throughout the whole operation.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE

Accidents and urgent cases of all kinds are admitted by the Maze Pond entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Hale White (2), Mondays, Tuesdays and Thursdays. Dr. Shaw (2), Mondays, Tuesdays (10.30), Thursdays (10.30) and Fridays. Dr. Fawcett (2), Mondays, Tuesdays, Thursdays and Fridays. Dr. Beddard (2), Mondays, Tuesday and Fridays.

Surgical Wards.—Sir W. Arbuthnot Lane (2), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Mr. Dunn (1.30), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Sir Alfred Fripp (1.30), Tuesdays and Fridays. Mr. Steward (1.30), Mondays, Tuesdays, Thursdays and Fridays. Operations (1.30) daily.

Obstetric Ward.—Mr. Bellingham Smith (2), Tuesdays and Fridays. Mr. Chapple (2), Mondays, Wednesdays and Thursdays.

Ophthalmic.—Mr. Eason (2), Mondays and Thursdays. Mr. Ormond (2), Tuesdays and Fridays. Operations (2), Tuesdays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Hunt (1), Mondays. Dr. Cameron (1), Wednesdays. Dr. Hertz (1), Thursdays. Dr. French (1), Fridays. Dr. Poulton (1), Saturdays.

Surgical Cases.—Mr. Turner (1), Mondays. Mr. Fagge (1), Wednesdays. Mr. Rowlands (1), Thursdays. Mr. Hughes (1), Saturdays. Mr. Davies-Colley (1), Tuesdays and Fridays.

Obstetric.—Mr. Chapple (1), Mondays. Mr. Bellingham Smith (1), Thursdays.

Ophthalmic.—Mr. Eason (1), Tuesdays and Fridays. Mr. Ormond (1), Mondays and Thursdays.

Children's Diseases.—Dr. Cameron (1), Mondays; (9), Fridays.

Dental.—The Dental Staff (9) every week-day.

Throat and Ear.—Mr. Mollison (1), Tuesdays and Thursdays. Mr. Layton, Wednesdays and Fridays.

Skin.—Sir Cooper Perry (1), Tuesdays.

Electro-Therapeutic.—Dr. Hertz (1.30), Wednesdays and Thursdays.

Actino-Therapeutic.—Mr. Iredell (9.30), every week-day.

Orthopædic.—Mr. Trethowan (9), Tuesdays & Thursdays.

Nervous Diseases.—Dr. Hertz (9), Wednesdays.

Genito-Urinary.—Mr. Thompson (9), Wednesdays and Saturdays.

DENTAL SCHOOL.

The dental student is supplied at the Medical School Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the time for about two months. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These manipulations upon the dummy, when done in a thoroughly sound manner, form an excellent ground-work in operative dentistry.

Pupils in Dental Mechanics are received at the hospital, and a systematized and graded course of instruction is carried out by competent teachers.

The regulations of the Royal College of Surgeons of England require that students shall pass two professional examinations for the dental licence. At the first examination certificates must be produced, *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon, or under the direction of the superintendent of the mechanical department of a recognised dental hospital, during a period of two years, and of having manufactured and adjusted six dentures and six crowns.

As this examination may be passed in the month of May, the work of the first winter session should be largely devoted to demonstrations, dental mechanics, and lectures.

Students in difficulties about their work and needing advice are invited to consult the Dean, or any member of the Staff, who will be pleased to do what they can to promote the interests of students.

SPECIAL DEPARTMENTS.

There are at present ten special departments in the Hospital, namely, Throats and Ears, Eyes, Skins, Gynæcological, Nervous, Children, Actino-therapeutic, Electro-therapeutic, Orthopædic and Genito-urinary. In all these departments the latest methods of diagnosis and treatment are to be seen, and much valuable information may be gained by the student.

The Choice of a Microscope.

Immediately on entering the hospital our medical student finds himself faced with a problem of serious import, although he may at the moment fail to recognise it as such, viz., the Choice of a Microscope. The present-day study of medicine necessitates the use of the microscope from the most elementary stages until the moment when our fully-fledged medico leaves his *alma mater*, and, indeed, after that, if he is to put into practice the many aids to diagnosis which he has studied in the hospital laboratories. Occasionally it happens that he is already provided with an instrument of weird and wonderful design which served his forbears during the early days of microscopy, but such an instrument is useless at the present day. A comparatively simple microscope is adequate for the work carried out in the biology class, where our student first comes to hand-grips with the microscope, but it must be borne in mind that later, when studying histology, and more particularly when he embarks upon the study of bacteriology, a really sound instrument and first-class lenses become absolutely essential.

We would impress upon the man who enters the hospital totally unfamiliar with microscopical work, the fact that the services of his teachers, whose experience in microscopical matters is extensive, and has been quickened by the observation of difficulties encountered by past generations of students, are always at his disposal. There should, therefore, be nothing to prevent him from purchasing at the very outset of his student's career, a microscope stand of thoroughly sound construction, and of such a pattern that the additions necessary to fit it, even for research work, can be added from time to time as the necessity arises, at comparatively small cost.

Although some twenty or thirty years ago Continental makers were unrivalled in the manufacture of microscopes, and still retain much of the reputation they then gained, yet at the present day the stands made by some of the British firms are undoubtedly superior in materials, workmanship, and attention to constructional details, and we would strongly urge the purchase of a stand of English manufacture; such for example as the Stand H (Edinburgh Students) made by Messrs. Watson & Sons, 313, High Holborn. This is of the tripod pattern, jointed, provided with a rack work, coarse adjustment, fine adjustment of the lever type, large stage, with square opening, fitted with mechanical movements, compound sub-stage (to which additional apparatus may be attached in the future), and a swinging double mirror, plane and concave, and costs about £10. The addition of a 1in. lens, a $\frac{1}{6}$in. lens, and two eye-pieces, one magnifying two diameters, the other eight, at the cost of about another £3, provides the student with an instrument which will prove a faithful friend during the preliminary studies of biology and physiology. It will also serve him for his morbid histology, and when he enters the bacteriological class he will merely need to add an Abbé sub-stage condensor, costing from 15s to £1, a triple dust-proof nose-piece, £1, and a $\frac{1}{12}$in. oil immersion lens, which will cost him a further £5. Practically all the standard makers put a really good immersion oil lens upon the market at this figure, the best being those supplied by Watson & Sons, Crouch (Agents, Messrs. Maw, Son & Sons), and the Continental firms of Zeiss, Leitz, and Reichert.

In chosing a microscope it is not always true economy to obtain the entire equipment from any one firm; and it may be well at times to get a stand from one maker, the lens from another, the second lens from a third, and so on, for all lenses, etc., are made to standard screws, therefore accessories manufactured by different firms are interchangeable; and in this connection the expert knowledge of his teachers in the medical school is so valuable to the student.

Such a microscope as we have sketched out is the ideal from the point of view alike of the student and the teacher; but in some instances the initial cost may be greater than the student cares to incur, and if this is so, he will find that nearly all the reliable firms make less costly models, which will serve his purpose. For a student's microscope of proved reliability, Messrs. Watson & Sons' "Stand F" and "Fram" models are to be recommended; these instruments, with 1in. and $\frac{1}{6}$in. objectives, eye-piece, and case cost £7 17s. and £6 5s. respectively.

Or again, the student may occasionally be able to acquire a good second-hand microscope comparatively cheaply, but such an instrument should never be purchased unless he can obtain it on approval, and submit it to expert opinion before completing the purchase, especially if the microscope is to be obtained from a pawnshop or second-hand dealer. A good plan, often productive of marvellous bargains, is to enquire of some first-class firm whether they have an instrument of their own make for disposal second-hand, as it sometimes happens that a microscopist disposes of a particular microscope in part-payment for a more expensive model,

and in this case the purchaser of the second-hand instrument obtains the guarantee of the maker that the microscope is in good condition. Second-hand lenses may also be picked up occasionally; Messrs. Baker & Co., High Holborn, and Messrs. Millikin & Lawley in the Strand, usually have a good selection of second-hand lenses. Slide boxes or cabinets to contain finished slides can be obtained of any of the microscopical instrument makers, the nearest being Messrs. Stanley, whose place is close to London Bridge Station.

Instruments.

Both in the wards and in the dissecting-room and the physiological laboratory the student will find that he needs several instruments. In the wards he will want a stethoscope, dressing instruments, tape measure, blue pencil, and possibly such instruments as an ophthalmoscope, etc., and, in his previous work, a dissecting case is an absolute essential.

There are many instrument makers in London, the majority of whom make a point of catering for the new student.

The student would do well to give Messrs. Down a call and inspect their large and varied stock of dissecting cases, dressing cases, midwifery bags, etc. The firm supplies all apparatus necessary for work in the wards or in the laboratories, and all their material is of the best quality. The Holborn Surgical Instrument Company, Ltd., 26, Thavies Inn, Holborn Circus, E.C., have also a large stock of instruments, at comparatively cheap prices, while Messrs, Millikin and Lawley, Strand, London, W.C., have always on hand a large variety of new and second-hand instruments and bones.

At all these firms the student may obtain blood-counting apparatus, ophthalmoscopes, pocket spectroscopes and other desirable, if not absolutely indispensable, instruments. Messrs. Watson and Sons, of 313, High Holborn, and Mr. Baker, of 244, High Holborn, however, list special sets of blood-counting apparatus designed for students and clinical use, and in addition stock several sets of microscopical apparatus, including stains, etc. Messrs. Stanley, Station Approach, London Bridge, who are opticians to Guy's Hospital, have a large and extensive stock of microscopical apparatus, such as slides, specimen boxes, etc., and their shop is conveniently situated for those who cannot afford much time. Their articles are of excellent manufacture, and thoroughly satisfactory.

Books.

The student who wishes to obtain his books at once should *not take the first he sees on any particular* subject, but would be wise to consult his demonstrators first; the number of text-books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co. publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co.; Philip & Son; Cassell & Co.; Nisbet & Co.; and Baillière Tindall & Cox.

As we have mentioned, it is rarely that second-hand books will be required, but there are cases in which they are valuable. Mr. Chas. Sawyer. 29–31, New Oxford Street, W.C., has a long list of last editions at very moderate prices, and there are other second-hand booksellers.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

Osteology.

The question of the purchase of bones is always an important one. Millikin & Lawley, in the Strand, make a speciality of supplying the medical student with this part of his equipment.

Guy's Hospital Clubs' Union

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Year Book, p. 13) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres

in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Return tickets at single fare are issued by the Brighton Railway Company. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

CONSTITUENT INSTITUTIONS.

THE CRICKET CLUB.—President: C. H. Fagge, Esq., M.S., F.R.C.S.; Captain: B. Sampson; Hon. Sec. and Treasurer: L. H. Dixon.

Matches are played throughout the summer session, fixtures being made for two XI.'s. There are both a Senior and Junior Inter-Hospital Cup. Guy's has won the Senior Cup eighteen times since its inauguration in 1882. The Junior Cup has been in existence eight seasons. Guy's has won it five times.

Practice matches are held early in May, and all freshmen should put their names on the list. Blues are given to the members of the Cup team, and Half-Blues to some members of the 2nd XI.

The Annual General Meeting will be held in March.

THE FOOTBALL CLUBS.—President: John Fawcett, Esq., M.D. Rugby—Captain: L. R. Broster; Hon. Sec.: C. L. Curle; Captain 2nd XV.: K. Day-Lewis; Captain 3rd XV.: E. N. Glover; Captain 4th XV.: G. B. Dowling; and a committee of five, one representing each year. Association—Captain 1st XI.: A. C. M. Coxon; Hon. Sec.: L. Gill; Captain 2nd XI.: J. L. Bensted; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over sixty years. Very little is known of its early history. Among the many well-known players who at one time or another have played for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (Captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon, A. Alcock, H. Lee, H. Archer, G. R. Hind (England); H. H. Jordan, E. Morgan, J. P. Jones (Wales); R. Evans (Scotland); F. O. Stokes (Ireland).

The Inter-Hospital Challenge Cup was instituted in 1874, and Guy's had the honour of being the first holders. Since then Guy's has held the Cup sixteen times, St. Thomas's ten times, London six times, St. George's three times, St. Bartholomew's twice, and Middlesex and St. Mary's once each. In 1891, Guy's, Middlesex, and St. Thomas's were left in, the ties not being played out.

The Association Football Club was founded in 1882, and a high measure of success has rewarded its efforts from its earliest days. Four years later (1886) the Inter-Hospital Challenge Cup (Senior) came into existence, and of the twenty-six occasions it has been competed for, Guy's has "been on top" no fewer than twelve times, St. Bart.'s being our nearest opponents with five wins.

All fixtures for this season have been abandoned owing to the war.

THE LAWN TENNIS CLUB.—President: Sir W. Arbuthnot Lane, Bart., M.S.; Vice-President: J. Fawcett, Esq., M.D.; Captain: W. R. Reynell; Hon. Sec., A. Traill, and a committee of six students.

The Lawn Tennis Club was founded in 1888. Two teams are run during the season, which starts on May 1st and finishes at the end of July. There are two Inter-Hospital Cups. The Senior Inter-Hospital Cup was won again this year, and thus remains in our possession for the seventh year in succession. A trial game is held early in the season, and tournament singles are played for the Arbuthnot Lane Cup during the season.

THE ATHLETIC CLUB.—President: J. Fawcett, Esq., M.D., F.R.C.P. Hon. Secs. and Treasurers: J. R. Barrow-Clough and E. S. Bowes, and a committee of eleven. The annual summer meeting is held in June, when the Lucas Challenge Cup is competed for, at the Clubs' Union ground. The team which represents Guy's in the Inter-Hospital Sports is chosen on the results of our sports. Blues and Half-Blues are awarded at the discretion of the committee. There is also a contest between the United Hospitals and Dublin University when possible.

In connection with the Athletic Club there is a Cross-Country Club, which has runs every Saturday, and races with the leading London clubs, and the Universities of Oxford, Cambridge and Dublin. Half-Blues are awarded in the Inter-Hospital Cross-Country race. Full particulars and notices of all club matters are to be found on the colonnade notice-board and in the smoke-room.

THE GOLFING SOCIETY.—President: G. Newton Pitt, M.D. Vice-Presidents: H. C. Cameron, M.D., H. L. Eason, M.D., M.S., C. H. Fagge, M.S., F.R.C.S., J. Fawcett, M.D., A. W. Ormond, F.R.C.S., F. J. Steward, M.S., F.R.C.S., R. Davies-Colley, M.C., F.R.C.S., and E. C. Hughes, M.C., F.R.C.S. Committee: O. Morgan, G. Noott, F. A. Knott, F. G. L. Scott. Hon. Secretary and Treasurer: R. Curle.

This society was formed in May, 1908, for the purpose of promoting Inter-Hospital Golf, and also to provide local interest by means of competitions, matches, etc. The society is affiliated to the Clubs' Union, and therefore all members of the Union are members of the society.

Matches are arranged with other hospitals and clubs. Competitions, open to staff and students, are held three or four times a year, due notice of which is posted in Colonnade and printed in GAZETTE.

An arrangement has been made by which members of the above society may play on five days in the week—viz., Monday to Friday—at the Ilford Golf Club, on payment of an annual subscription of £1 1s., without entrance fee Such members may play on Saturdays, Sundays and Bank Holidays at the rate of 2s. 6d. a day.

We are indebted to the Committee of the West Essex Golf Club for the following arrangements:—Members of the Guy's Hospital Golfing Society may become five-day members of the West Essex Golf Club on payment of an annual subscription of two guineas, without entrance fee. Such members may play on Saturdays and Sundays on payment of a daily green fee of 2s. 6d. Members of the Society may play at West Essex any day, except Sunday, at a green fee of 2s. 6d. a day, On Sundays the green fee is 5s., unless accompanied by a member of the West Essex Club, when it remains at 2s. 6d. An arrangement has also been made with The Foxgrove Club, Beckenham, by which members of the society may play on any day, by payment of a green fee of 2s. 6d.

HOCKEY CLUB.—President: F. J. Steward, Esq., M.S., F.R.C.S. Vice-Presidents: A. W. Ormond, Esq., F.R.C.S., and C. H. Fagge, Esq., M.S., F.R.C.S. Captain: J. F. Venables; Hon. Secs and Treasurers: G. D. Gripper and R. W. P. Jackson.

Owing to the war all fixtures for this season have been abandoned.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir James Goodhart, Bart., M.D., LL.D. Hon. Vice-Presidents: Frederick Taylor, M.D.; Sir Geo. H. Savage, M.D.; C. J. Symonds, M.S. Hon. Secretaries: G. T. Mullally, M.B., B.S.; T. B. Heaton, M.B., B.C.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets each fortnight on alternate Wednesday and Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion. "Clinical" and "Pathological" Evenings are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member. The society offers a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session.

THE DEBATING SOCIETY.—President: L. E. Shaw, M.D. Vice-Presidents: J. Fawcett, M.D., A. W. Ormond, F.R.C.S., H. C. Mann, M.D., M.R.C.P., A. R. Thompson, F.R.C.S., T. B. Layton, F.R.C.S. Hon. Secretaries: G. Neely, and T. L. Heath. A committee of the Secretaries and six students.

Members of the Clubs' Union, junior as well as senior, are specially invited, in their own interests, to attend as many as possible of the meetings of this society.

The endeavour has been made to choose subjects within the scope of the limited interests of the medical student, and it is hoped that all will try to be present who are not too blasé to listen to the views of others, or too slack to give others the benefit of their own.

The list of debates will be published in the GAZETTE anyone willing to take part is particularly requested to communicate with the Secretary.

THE DENTAL SOCIETY.—President: F. B. Bull, Esq. Hon. Secretary and Treasurer: W. J. Rousseau Viljoen.

The object of this Society, which was founded in 1894, is the promotion of interest in Dental subjects, and the discussion of Dental topics. Papers are read before the Society each month, and a prize (value £5) is awarded for the best paper read before the Society during the session. Casual communications are invited at all meetings, and a prize (value £1) is awarded at the end of the session for the best set produced.

One meeting during the session is set apart for the examination and discussion of cases of special interest, the patients being brought up for examination.

The meetings are held every month during the winter session in Class Room No. 2 in the Medical School Buildings. The meetings take place at 4 p.m. on the second Friday in the month, and tea is served before the meetings for members attending the meetings. New men are strongly urged to attend and take part in these meetings, which, in the past, have proved instructive as well as interesting.

THE GUY'S HOSPITAL REPORTS.—Edited by F. J. Steward, M.S., and Herbert French, M.A., M.D.

The Reports are published annually, and each subscriber to the Clubs' Union is entitled to a copy, which he may obtain in the Wills Library from the Librarian. Each volume contains papers by members of the Staff of the Hospital and Medical School upon original work done in the Hospital during the preceding year; it also contains a list of the gentlemen who have been educated at Guy's Hospital, with the appointments they have held during the year, the examinations they have passed, and the prizes and honours they have won. The first

volume appeared in 1836; copies of the earlier volumes can be obtained from the Editors. The value of this annual publication is obvious, and every Guy's man is proud of the original papers of its Staff, from those of Addison, Bright, and Hodgkin, to those of the present day.

THE STUDENTS' CLUB.—Officers till 1914 (March). President: W. Hale White, M.D.; Treasurer: John Faweett, M.D.; Hon. Secretary: T. B. Layton, M.S.; Hon. Assistant Secretary: H. Gardiner, M.B.; and a committee of eight.

The above named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book.

GUY'S HOSPITAL CHORAL SOCIETY.—This Society will begin rehearsals for the Winter Season early in October. The practices are held every Friday, at 5 and at 8 p.m., in whatsoever room shall be deemed convenient for the occasion. Notices are posted on the screens opposite Astley Cooper door, in the Dissecting Room, and in the Students' Cloak Room, Medical School.

Since the success, and, indeed, the very existence of the Society depends entirely upon the keenness and enthusiasm of those students who are musically disposed, it is hoped that all freshmen who have voices, or other musical talent, will announce the fact by their presence at the rehearsals.

All particulars may be obtained from the secretaries, H. Q. F. Thompson and J. J. Sterling-Hill.

BOXING, FENCING AND GYMNASIUM CLUB (The Pavy Gymnasium). President: H. L. Eason, Esq., M.S.; Treasurer: W. M. Mollison, Esq., M.C. Committee: Messrs. G. T. Mullally, Faskin, Portway, Maelzer, E. A. Leviseur, Coe, and Whitten. Hon. Secretary: F. W. Stiven.

The Pavy Gymnasium, which was built and endowed by the generosity of the late Dr. Pavy, is situated in the Quadrangle of the College, and is open to members of the Clubs' Union at all times.

Throughout the winter session, classes conducted by thoroughly competent instructors are held weekly in boxing, fencing and gymnastics. An excellent wrestling mat has recently been acquired by the club, and if there is sufficient support an instructor in wrestling may be engaged. At the end of the winter session an Annual Assault-at-Arms is held, and a team selected to compete in the Inter-Hospital Boxing, etc.

All men who are interested in this club are earnestly requested either to make themselves known to the Secretary or to one of the Committee, or to turn up to the Classes in the Gymnasium at the advertised times.

Appointments.

Royal Army Medical Corps.

Major A. E. Milner is placed on retired pay, dated July 28th, 1914.

A. W. Ormond, Esq., F.R.C.S., has been appointed Ophthalmic Surgeon to No. 2 Base Hospital, Chelsea.

It is notified for general information that the undermentioned officers will be required to proceed to the Commands specified during the coming trooping season.

Northern Army, India.—Major L. Humphry, Oct. 8th.

Eastern Command.—Capt. G. H. Rees; Capt. H. G. Gibson.

Irish Command.—Capt. G. D. F. Churchill.

The following are granted the temporary rank of Lieutenant:—W. T. Milton, J. A. Andrews, G. D. Eccles, P. Smith, V. Glendining, H. W. Evans, H. C. Lucey.

F. F. Burghard, M.S., Capt., R.A.M.C.(T.), and A. H. Tubby, M.S., Major, R.A.M.C.(T.), have been appointed to No. 4, London Base Hospital.

Capt. A. M. Daldy, R.A.M.C.(T.), Capt. L. A. Parry, R.A.M.C.(T.), and Capt. W. R. Wood, R.A.M.C.(T), to 2nd Eastern General Hospital.

Lieut.-Col. Wheelton Hind, O.C. North Middlese Heavy Battery, at present at Luton.

Capt. J. M. Fortescue-Brickdale, R.A.M.C.(T.), to 2nd Southern General Hospital.

Lieut. T. S. Allen, R.A.M.C.(T.), No. 12, Genera Hospital.

G. F. Stebbing, Royal Marine Depôt, Queenstown.

F. Cook, R.A.M.C., Special Reserve, Woolwich No. 11 Hospital.

M. Scott, R.A.M.C., Devonport.

E. Billing, R.A.M.C., Devonport.

R. D. Passey, R.A.M.C., Special Reserve, Woolwich, No. 4 Hospital.

V. Townrow, R.A.M.C., Portsmouth.

J. Lennox Stewart, R.A.M.C., Woolwich, No. 8 Hospital.

R. B. Campion, R.A.M.C. (No. 1 Ambulance Train), Expeditionary Force.

Artists' Rifles Territorial Force.

C. H. Brewer, G. W. Elkington, J. S. H. James, G. P. Lindsay, C. G. Haynes.

Casualties.

Capt. G. H. Rees, R.A.M.C., missing.

Lieut. J. L. Lauder, R.A.M.C., captured.

Capt. M. Leckie, R.A.M.C., formerly reported wounded, now reported wounded and missing.

Indian Medical Service.

To be Lieutenants: P. Savage, S. B. Venugopal.

To be Majors: Capt. L. Hirsh, Capt. H. C. Keates.

Royal Naval Medical Service.

The following announcement is notified by the Admiralty:—

Fleet Surgeon W. J. Bearblock to the *Invincible*.

H. H. Elliott, Temporary Surgeon Shotley Barracks, Harwich.

Civil.

Frederick W. Hall, M.D., M.S. Lond., has been appointed Honorary Physician to the Sydney Hospital, N.S.W.

O. R. L. Wilson, M.R.C.S., L.R.C.P., to be Assistant Medical Officer of the Southwark Union Infirmary.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Science and Practice of Dental Surgery. Edited by Norman G. Bennett, M.A., M.B., B.C. (Cantab.), L.D.S. (Eng.)

This book forms a comprehensive survey of the field of dental surgery and its allied sciences. It has been written by experts under the editorship of Mr. Norman Bennett. Although some names we should like to have seen are not among them, yet, as a whole, they inspire confidence. Nine past or present members of the Staff of the Dental School figure among the contributors. The book is somewhat bulky, and we think that as the subject matter is in independent sections, and does not form a continuous argument, the book might very well have been split into two volumes. The paper is good and the printing clear. Some of the illustrations are very poor, notably so where they deal with operative procedures, but in these it is particularly important that the detail of the figures should be accurate.

The opening section of the book deals satisfactorily with the development of the jaws and teeth, and is written by Mr. Coleman. We have also looked for a description of the naked-eye anatomy of the jaws, teeth, and soft parts in the adult, and its absence seems to us an omission of importance. One of the best sections in the book is that on orthodontia, in which the editor deals with the causes of malocclusion of the teeth and Mr. Chapman with their treatment.

In dealing with dental caries the part relating to foodstuffs is dealt with by Dr. Sims Wallace. The histology here as elsewhere is in the very able hands of Mr. Hopewell-Smith. Among the contributors to the treatment of the condition we find Mr. Parfitt, who deals with the arrangements of the operating room, the manipulation of gold, and with porcelain inlays; Mr. Dowsett, who writes on the Preventive Treatment of Dental Caries; and Mr. Hopson, whose subject is Plastic Fillings. These and the other contributors to this section have filled it with useful practical suggestions which well repay the most careful study, and will solve many problems which have presented themselves both to the experienced practitioner and to the inexperienced student.

As we have already stated, the lack of sharpness in the illustrations is a serious hindrance to the usefulness of this section.

Mr. Northcroft has written three excellent pages on the treatment of children's teeth. We wish that he had been a larger contributor to the book.

The subject of Periodontal Disease has been dealt with by Mr. Lewin Payne and by Mr. Hodgson. The chapter is well illustrated with micro-photographs and other illustrations. We regret that more space is not devoted to the extremely valuable contributions to the morbid anatomy and pathology of this disease which have been made by Mr. J. F. Colyer. Mr. Tilley deals with empyema of the antrum of Highmore in a very clear manner and is greatly helped by some excellent illustrations.

In conclusion we may express the wish that the writers' names stood in full at the head of each chapter. It is annoying to have to hunt at the beginning of the book to discover whose opinions are being read.

An Introduction to the Study of Organic Chemistry. By H. T. Clarke, D.Sc., F.I.C. (Longmans, Green & Co.) Price 6s. 6d.

The choice of a book which can confidently be recommended to students about to commence a study of organic chemistry is rendered more difficult than easy with the advent of new publications.

The book before us is one which deals with the introduction to the study of organic chemistry from the point of view of symmetry and homogeneity. Let us say at once that the author has been successful in the adoption of this plan, and the book, consequently, has much to commend it. It is refreshing to see in the quantitative estimation of nitrogen the calculation (p. 60) determines *directly* the amount of this element rather than introduce the equivalent figures for NH_3, a procedure which is so very often adopted by other authors. Some of the chapters are very brief, as, for instance, the one on uric acid and purines (p. 296). We think that the formula for purine might have been numbered with advantage so that the relations between the various derivatives mentioned could be seen at a glance; *e.g.*, xanthine is 2 : 6 dihydroxypurine, theobromine is 3 : 7 dimethylxanthine, caffeine is 1 :3 : 7 trimethylxanthine, etc.

Various teachers search in vain for a book which expounds their views in accordance with their method of instruction, and this, perhaps, explains the reason for so many text-books on the subject under consideration. We have no doubt Dr. Clarke's new volume will find many students who will derive benefit by its study.

Carbon Dioxide Snow, Its Therapeutic Uses. By J. Hall Edwards, L.R.C.P., F.R.S. Edin. (Simpkin, Marshall & Co.) Price 3s. 6d. net.

This volume is a short synopsis dealing with the methods of collecting, preparing, and applying carbon dioxide snow. The author, with the accompanying photos and diagrams in each chapter, explains lucidly all the principal properties of this useful preparation. Of special value to the practitioner are the notes dealing with the conditions which yield most successfully to its employment. In these the reader is enabled to reap the full benefit of a wide experience. The book is one which we can thoroughly recommend to all medical men.

X-Rays, an Introduction to the Study of Röntgen Rays. By G. W. C. Kaye, B.A., D.Sc. (Longmans, Green & Co.) Price 4s. 6d. net.

Though the author of this treatise appeals rather to the expert interested in the recent theoretical and practical developments of this complex subject, we believe the book will be found useful also to practitioners and students anxious to obtain a wider grasp of this branch of medicine and surgery.

Births.

BALL.—On September 11th, at Holmside, Emsworth, Hants, the wife of Malcolm Ball, M.B., B.S., M.R.C.S., L.R.C.P. Lond., of a son.

BLACKMAN.—On September 7th, at 11, Unthank Road, Norwich, the wife of H. G. Barham Blackman, M.R.C.S., L.R.C.P., of a daughter.

GAITSKELL.—On August 30th, at The Cottage, Lympstone, S. Devon, the wife of Charles E. Gaitskell, M.R.C.S., L.R.C.P., of a son.

HALL.—On June 3rd, at 30, College Street, Sydney, the wife of Frederick W. Hall, M.D., M.S., of a son.

MORLAND-SMITH.—On September 2nd, at The Hive, Exeter Road, Bournemouth, the wife of T. Morland-Smith, M.R.C.S., L.R.C.P., of a son.

Marriage.

DENNING — BURNS. — On September 2nd, at All Hallows, London, Arthur Ffolliott William, M.B., B.S. Lond., youngest son of J. V. Denning, Surgeon, of London, to Adelaide Mary E., second daughter of the late James and Mrs. Burns, of Southsea.

Deaths.

ALCOCK.—On the 19th September, at 12, Barton Street, Gloucester, Ruth, wife of Arnold Alcock, M.B., B.S., in her 29th year.

HOWSE.—On September 15th, at the Tower House, Cudham, Kent, Sir Henry Greenway Howse, M.S., D.Sc., F.R.C.S., Consulting Surgeon, Guy's Hospital, late President of the Royal College of Surgeons of England, in his 73rd year.

TANNER.—On September 8th, at his residence, 8, Glenmore Road, N.W., John Tanner, M.D., &c., late of Queen Anne Street, suddenly of heart failure, in his 79th year.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Editor of the GAZETTE has made a momentous decision! He has forsaken the pen for a sword. Sitting in the vacant Editorial chair, I regard that pen with fear, for it is an instrument which is certainly quite as dangerous as the sword when used incautiously. After having sternly pointed out the path of duty for two months, the Editorial comment dealt sympathetically with the letters of "Old Guy's Man" (we wonder how old) and "Guyite," in the last issue. Why were these comments made? Because the subtle instinct of the GAZETTE perceived that an incalculable amount of good would be done by bringing forward a controversy which had to be made very prominent in order to settle it for ever.

THE letters from Mr. Symonds and Dr. Cameron have made the situation clear. The War Office has ample accommodation for wounded. We have one hundred beds available without neglecting our duties to the civil population. Many persons who must be included in the "world" quoted by "Old Guy's Man" warmly approve of the action taken by the Governors and Staff in adopting a "Business as usual" policy during the war. "Old Guy's Man" admits the necessity of maintaining an efficient service for the civil population. When there is no provision for war victims, then the time will arise to consider what arrangements must be made regarding the admission of cases which are not urgent.

IT is very bold to peep into the future and prophesy that Guy's will lose prestige by not slavishly following the lead of other London hospitals. Surely there is more than one path of duty in a national crisis; there must be some division of labour. Other hospitals are doing their part and we must continue ours. We must not hesitate and falter because we shall get no "Kudos." The loyalty of the residents and students to the Hospital is made nobler if it entails the sacrifice of work which is more satisfying to one's vanity. Let us have no fear for the future of the Hospital. Time will completely vindicate our independent action.

IF "Old Guy's Man" were in the Hospital at the present time he would soon convince himself that the Hospital workers are quite "active" whilst practising a high form of patriotism. The Hospital cannot lose prestige through doing its obvious duty, whilst fully prepared for

any emergency that may arise. Donors to the Hospital will not be troubled with the wonders of the "world." Their money is not intended to support empty beds. If their generous donations are used to the best possible advantage, they will, as business men, continue to support the Hospital. A cynic once described a friend as a man with a keen sense of the personal benefits likely to result from his friendships. It would be deplorable to adopt this as our standard of duty to the sick and wounded soldiers.

Whatever the future holds in store for us at present we have no cause to be pessimistic regarding the prestige of the Hospital. On Tuesday last Lady French paid us a visit and was "on duty" in Stephen Ward, to present a new flooring of British Plantation Rubber, on behalf of the Rubber Growers' Association. Such a graceful compliment was greatly appreciated. Lady Goschen and Lady Jellicoe were also present.

To Lieut. H. L. Hopkins falls the honour of being the first Guy's man to be killed with the Expeditionary Force. We tender our sincere condolences to his family. It is very sad to be cut off just at the end of a long apprenticeship to the profession, in the flower of manhood, but such is the toll of war!

We congratulate Corporal C. P. Symonds, of the Motor Scouts, Expeditionary Force, on his narrow escape from death. He was invalided with a piece of shell in the thigh to No. 2 Base Hospital, and is making good progress. Guy's men look forward to reading his experiences when he is able to write them for the Gazette.

We hope many other Guy's men with narratives of the war will follow the excellent example of Mr. O. G. Morgan, who contributes to this issue. The photographs reproduced had a very narrow escape at the hands of the Germans in Brussels. The note book containing these experiences was rapidly transferred from one pile of papers to another whilst the "spy catcher's" back was turned.

The visits paid by large numbers of children with coughs and minor surgical ailments, many of which are self-inflicted, to the Out-Patient Department, seems to remind us that Christmas is rapidly approaching. How the Borough children look forward to these annual entertainments. One child exhibited to an amused crowd of men an obviously self-inflicted scratch which she informed her audience recurred regularly every October. Unfortunately, owing to L.C.C. regulations, there will be no cinematograph entertainment this year. It is hoped that generous support will be given to the Landon Tea Fund. The children must, if possible, have a better time than ever this year.

Mr. Dunn paid a visit to the Hospital last week. Such good progress has been made that he intends to examine at the Final Fellowship in November. The entries of students up to the 7th of October have been well up to the average. At a meeting of the Staff arrangements were made to grant leave of absence for one year, or in the event of the war lasting less than a year, until the conclusion of the war, to Dr. A. J. Clark, the Greville Lecturer on Pharmacology; Mr. G. Marshall, the Demonstrator of Physiology; Dr. T. B. Heaton, Medical Registrar; Mr. J. A. Ryle, the oncoming Medical Registrar; Messrs. E. G. Schlesinger, R. C. Ozanne, and G. T. Mullally, the oncoming Surgical Registrars and Demonstrators of Anatomy.

Capt. A. T. Falwasser, R.A.M.C., T.F. (an old Guy's man) commanding the 1st (Home Service) Home Counties' Field Ambulance, with Headquarters at the Old Palace, Maidstone, appeals for Officers to complete the establishment of his unit. He will be pleased to answer any enquiries at the above address.

Papers, etc., Received.—Clinical Journal, M. S. Journal, Nursing Times, Prescriber, Polyclinic, New York State Journal of Medicine.

Presentation of Rubber Flooring in Stephen Ward.

Stephen ward was, on Tuesday afternoon, the scene of a very pleasing ceremony, for it was the occasion of the presentation, through the gracious agency of Lady French, wife of the popular Commander-in-Chief of the Expeditionary Forces, of a complete flooring throughout the ward of British plantation rubber, which had been generously given by the Directors of the Rubber Growers' Association, represented at the gathering by Mr. William McEwan.

On the neat little dais at the ward entrance the chair was occupied by Mr. Cosmo Bonsor, supporting whom were Lady French, Lady Goschen, Viscount Goschen, Sir Cooper Perry, Sir W. Arbuthnot Lane, Dr. Hale White, Dr. Fawcett, and others. Lady French was, on entering the ward, presented with a very tasteful bouquet by Master Percy Harris.

Mr. W. McEwan, Chairman of the Rubber Growers' Association said: The inception of the idea that to-day is having its realisation came in a West-end Nursing Home near Harley Street. A prominent rubber planter was lying there a few years ago after an operation performed in the hot days of summer. All the doors and windows were wide open for fresh air, and the noise of the street traffic was terrible. It then occurred to me that if all the nursing homes in London could be moved into one of the quiet *cul de sac* squares of the East End, and the roadway therein paved with rubber, the comforts of the patients would be added to, and their chances of final recovery improved. That being an idea afar off, and, for the time being impracticable, I then thought of paving with rubber the streets surrounding some of our City hospitals. Here the difficulty was that the Local Authorities had not yet been converted to permitting such revolutionary improvements. Determined that hospitals should in some way benefit, I proposed to my associates that we should combine together to do the work that we are now looking at. The cordial concurrence of Sir Cooper Perry, the Superintendent, and the Governing Body was given after they had satisfied themselves on various practical points, and you now see the result. The members of the Rubber Growers' Association responded so generously that instead of this flooring being the only gift, we received contributions in kind enabling us to do about four times as much as you now see. (Applause.) About 170 of the producing companies contributed. A large installation was given to the Edinburgh Royal Infirmary in August, and on Friday next week Lady Jellicoe has undertaken to hand over our gift of flooring to the Children's Hospital, Great Ormond Street. (Hear, hear.) The Church of St. Michael's Cornhill, has just been re-opened after completing a new rubber flooring. The Rector considers it has greatly added to the acoustic properties of the building, and the organist has declared that its resonant qualities are such that the musical effect is improved by some 25 per cent. This was an entirely unexpected result, so far as we are concerned, but I hope the peace and quietness of this ward may reduce the period of recovery in a similar proportion, and so promote the efficiency of the Hospital. (Applause.) We feel deeply indebted to Lady French for coming here to-day—(Applause)—and honouring us by handing over our gift. It may interest her and you to know how much the rubber industry is concerned in the war. When the time comes to tell the full story of how the Government were forced, two weeks ago, to declare rubber conditional contraband, another of the romances of commerce will be unfolded. The story of the efforts of our great enemy to secure the essential for replacing his airships, motor tyres, and innumerable other articles; and the manner in which, at every point, he has been headed off by the assistance of those whose business it is to grow and sell rubber, will make a good story in the telling. (Hear, hear.) At present, all the rubber manufacturers are busy producing waterproof ground sheets for the Army, besides surgical goods of endless variety. Our Association, only yesterday, voted a gift of one thousand hot-water bottles, made from the best plantation rubber, to the British Red Cross Society for their work—(Applause)—and we are urging the Government to fit out the soldiers with rubber boots such as the Russian people wear, to help them to face better the period of winter snow and damp to which they are likely to be exposed. (Hear, hear.) In conclusion, I wish to acknowledge the great courtesy and interest in this new departure shown by Sir Cooper Perry and the Executive of the Hospital, and express the hope that they will find it exceed in use all the most sanguine expectations of the donors. (Applause.)

Lady French, who on rising was received with great cordiality, said: I have great pleasure in handing over to the Hospital this beautiful

flooring, which has been so handsomely presented by the Rubber Growers' Association. I am sure the patients will find it of immense benefit. (Applause.)

The Chairman (Mr. Bonsor): Lady French, my Lord, ladies and gentlemen, on behalf of the Governors of this Hospital—and I think I may also say on behalf of the medical, the surgical, and the nursing staff,—I have the honour to accept this gracious gift from you, Lady French. It may be of some interest to Lady French, Mr. McEwan, and the members of the Rubber Association, to know that the ward in which we are met to-day is one of those wards which, during the financial stress under which Guy's Hospital suffered, was closed; there were no patients in it. It was the late King Edward who came forward with his scheme for rehabilitating the income of Guy's Hospital, and in co-operation with other noble donors, gave the Governors the means for renovating and re-opening these wards. It was then the duty of Sir Cooper Perry and myself to consider what was the best flooring that could possibly be devised for a hospital ward. We commenced with Queen Victoria ward, which is on the storey above this, and there we put in Italian mosaic. That was not altogether up to our ideal; and other wards we have floored with glass mosaic, which is very good for durability, cleanliness, and wear. In the old building, which we passed through on our way here, the old Guy's House, which is given up entirely to surgical wards, I regret to say that the structural condition would not allow of anything but wood flooring. There we have experimented with parquet, with teak, and with Australian hardwood. But it is to-day, if I may say so, that the Rubber Association has produced what we all of us must consider an ideal flooring. (Hear, hear.) For that we are extremely grateful. We have had from people in the past many gifts in kind, but to-day I take it we may say that though this is the last it certainly is one of the most useful and one of the most valuable. (Applause.) Mr. McEwan, in his opening remarks, was good enough to tell us of the great generosity of the Rubber Association to other institutions as well as to Guy's Hospital. We who belong to the general hospitals of London know full well how closely commerce and charity are intertwined. I do not suppose any one of these hospitals would be able to do its duty to the suffering poor unless we had behind us the great resources of the commercial community of London. (Applause.) We thank you, Mr. McEwan, and the Rubber Association, for this most noble gift to-day. I have said it is an ideal flooring. May we invite you, Sir, and the other members of the Association, to come here in three or four months' time? Then we shall be able to see—what we confidently anticipate—how well it wears, and how great a comfort it proves to be, not only to the patients, but also to the nurses of the ward. To walk along it shows how quiet and comfort-giving it is, and no dust arises from it. We believe you have produced for the hospitals of London the flooring of the future, and in accepting the gift, I thank you heartily on behalf of the Governors. (Applause.)

Viscount Goschen: Lady French, ladies and gentlemen, I had no idea that I should be asked to speak, but I was delighted that Mr. Bonsor was able to come, and I am sure all connected with Guy's will be glad to see him here again after his recent illness, for we realize how much Mr. Bonsor has done for this Hospital, and that he has been able, on behalf of the Governors, to receive this flooring. I merely rise to ask you to tender a most hearty vote of thanks to Lady French for her kindness in coming here to-day. (Applause.) I am sure we feel deeply indebted to her for taking this interest in the Hospital, and for formally receiving this flooring to-day. I am sure we think of Lady French at the present time, and entertain towards the family feelings of deep gratitude. As Mr. Bonsor has said, we receive with great gratitude this flooring from the donors. All who walk about on hospital floors will realise how the nurses and patients will enjoy this flooring. I could not help wondering, as I heard Mr. McEwan speaking, whether it would not be possible for him to extend this laying of rubber flooring. I come from a district, near Sandwich, where we have been doing route marching on the roughest of roads; and if this flooring—(laughter)—could be carried out there, it would be of immense benefit to the many thousands of troops who are marching along it. (Laughter and applause.)

The resolution of thanks was carried by acclamation.

Tea was then served in the ward.

Change of Address.

Dr. A. R. F. Evershed, from 13, Harley Street, to 22, Harley Street, Cavendish Square. Telephones, Mayfair 6498, and Hornsey 2393.

Some Recent Researches on the Etiology of Psoriasis.

By H. W. BARBER, M.B., M.R.C.P.

Psoriasis is one of the few common diseases the cause of which still continues to baffle research. The publication, therefore, of the results of two years' investigation of this disease by Schamberg, Ringer, Raiziss, and Kolmer in a recent number of the Journal of the American Medical Association is of great interest and importance. Their research was carried out upon two main lines, namely bacteriological and metabolic, and, seeing that the work was in the hands of experts, it deserves the most careful consideration.

The parasitic theory of the disease was first, I believe, suggested by Lang, and has been strongly supported by others. Various organisms have been described as possible causal factors at different times by different investigators, but none has been proved specific. Unna, while admitting that an external parasite is in all probability not the sole cause, has rightly pointed out that certain varieties of seborrhœic dermatitis resemble psoriasis very closely in appearance—the eczématides psoriasiformes of French writers—, and there is little doubt that these are directly due to micro-organisms, although their bacteriology, according to Sabouraud's researches, is complex. But we know that a morphological similarity by no means implies a similar etiology—witness the amazing mimicry of certain syphilitic rashes—, and the fact that the response to treatment is so different in the two cases is against the possibility of psoriasis being merely a variant of the group of seborrhœic eruptions. At the same time there is very considerable evidence that the disease is in part due to some external infection, and I still think the most reasonable view is that there is such an infection, which can only operate in the presence of some abnormality of metabolism, an abnormality which is probably in most cases congenital—*i.e.*, is a diathesis—, in others possibly acquired.

To turn now to the paper under discussion. The bacteriological investigations were carried out in the most exhaustive manner. The scales, serum, skin, and blood were all examined repeatedly for micro-organisms. In all, twenty-two varieties were isolated. Complement-fixation tests were performed, and vaccines prepared and administered; the ultra-microscope and many special methods of culture were also employed. All the results, however, were negative, in that there was no indication that any of the organisms isolated were responsible for the disease, and the authors remark that, while they have not abandoned their bacteriological researches, up to the present these have proved fruitless.

On the other hand, they claim to have obtained results of considerable interest in their studies of the metabolism of their psoriasis patients. They seem to have confined their attention almost entirely to the protein metabolism, making repeated and careful estimations of the urinary output of N with diets containing varying amounts of protein. Working on these lines they found that their patients retained a considerable quantity of N on diets which produce a state of equilibrium in normal persons; that on diets containing excess of protein they retained enormous quantities; and that they were capable of maintaining nitrogen equilibrium on extremely small amounts of protein. In other words, these patients were able to live in good health with a urinary output of N far lower than that of ordinary persons, and from clinical observations the authors came to the conclusion that a psoriatic should restrict himself to a diet containing not more than 5 grammes of N, and that his urinary excretion should not exceed 3·5—4 grammes per day. For they noted that an increased protein diet caused a spread of the eruption, and, on the other hand, that their special diets—containing less than 5 grammes of N—produced improvement without the aid of any external treatment.

The author's attempt to explain the influence of diet on the eruption is as follows:—They found that the scales of psoriasis, which consist of altered epithelial cells, are invariably composed of almost pure protein, and they conclude that a high concentration of amino-acids in the blood would lead to an increased production of these epithelial cells, and a consequent spread of the eruption.

The action of chrysarobin.—Of all the drugs that are used externally in the treatment of psoriasis, there is none that produces such rapid and satisfactory results as chrysarobin. It might, therefore, reasonably be expected that a study of its mode of action might throw some light on the pathology of the disease. Unna and Golodetz (*vide* Unna's "Biochemie der Haut") showed that its activity depended on the fact that it is very rapidly oxidized by the skin to chrysophanic acid. They consider that oleic acid plays an important part in this reaction, the action of chrysarobin being most marked in situations where this substance is most plentiful. The American authors undertook to investigate the antiseptic qualities of the drug. They employed the same methods by which they had previously studied the action of calomel on bacterial growth, both substances being insoluble. They found that whereas calomel has most remarkable powers of retarding the growth of bacteria, the antibacterial action of chrysarobin is extremely feeble. It is therefore obvious that since calomel has no appreciable effect on a psoriatic eruption, whereas chrysarobin acts better than any other known substance, the beneficial properties of the latter cannot be due to any antiseptic action that it may exert.

The authors conclude that its efficacy depends on the fact that it forms a very close combination with the protein of the epithelial elements which go to form the scales of the psoriatic patches.

Such is a short résumé of these researches. The authors do not claim to have solved the problem of the cause of psoriasis; they have merely published their results, and put forward some possible explanations thereof. When one comes to review their work, it must be admitted that its importance lies rather in the thoroughness of their investigations than in the actual results obtained. Their bacteriological researches were carried out far more exhaustively than has hitherto been attempted, and, although the fact that they were entirely negative does not preclude the possibility of some micro-organism being at any rate in part responsible for psoriasis, it does make it extremely unlikely that the disease is simply an external infection.

Their researches on the protein metabolism of their patients is very interesting, although, of course, they throw no light whatever on the reason for the marked retention of nitrogenous material which they describe.

I am not aware that such complete investigations on the metabolism in psoriasis have been carried out before, but Bulkley has described urinary changes which "indicate an imperfect metabolism of nitrogenous elements." He, however, remarks that the urine in psoriasis is usually of high specific gravity, markedly acid, and contains uric acid and urates in considerable excess; this would seem to be rather the contrary to the changes described in the paper under discussion. But Bulkley is equally enthusiastic as to the value of a low protein diet in the treatment of the disease. In 1911 he published a paper on 140 cases of psoriasis in private practice treated by a strict vegetarian diet, and he insists that this method of treatment, combined with the exhibition of alkaline diuretics, gives better results than any other, provided that the patient can be persuaded to adhere rigidly to the restrictions imposed.

These considerations would suggest that psoriasis is a constitutional disease—an index of disordered metabolism—, which, indeed, was the view of older authors, for whom, as Brocq says, the internal treatment was everything. As is well known, the majority of dermatologists to-day rely almost entirely on local treatment, and even the beneficial effect of arsenic is usually ascribed to its direct action on the skin. But, although psoriasis may be cleared and even cured by purely local measures, there are cases which fail entirely to respond to these, but, nevertheless, yield to constitutional treatment. A case which came under my notice was a good example of this kind. The patient was a Midlander, and was treated by several doctors without success. He was then placed under the care of an exceptionally able dermatologist for three months, but he gave the case up as hopeless. The unfortunate patient was in despair, and nearly committed suicide; fortunately his father had the sense to send him away, and he went to a well-known Welsh Spa. While there he drank the waters, and submitted himself to the régime prescribed. In three weeks his eruption had practically disappeared without the aid of any external treatment, and he was eventually completely clear. Since then he has had other outbreaks, some of them very severe; these have usually yielded to local treatment with chrysarobin, but he still considers Spa treatment the surest way to rid himself of an attack.

But the question may be asked:—"Why, if psoriasis be a constitutional manifestation, can it be cured by local applications?" There seems to me to be two possible answers:—(1) that the local applications do not affect the actual disease itself, but only the abnormal changes in the skin which the disease engenders, (2) that the local applications act partly locally, and partly, after absorption, on the entire system. Of the two the former seems the more likely.

In any case we are still a long way from understanding this troublesome disease, but this recent research should evoke further observations on the metabolism of those afflicted with it, both during their attacks, and in their periods of freedom.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Hospital and the Wounded.

Dear Mr. Editor,—The feeling that Guy's should receive some of the wounded is a natural one, but those who have read the letters from the Superintendent, offering to provide accommodation in the "Park," will know that the Governors have not been inactive or silent. We must remember that there are four special military hospitals of 500 beds, one of these—the 2nd London—is able of expansion to 1,000. There is ample accommodation at present. Several surgeons to other hospitals, and more than one prominent layman have asked me what Guy's was doing in the matter, and all warmly approved the action that had been taken and congratulated me on my hospital. I was, I must confess, proud to be able to say that while our hospital was prepared to provide 100 beds for the sick and wounded, it would do so without curtailing in any way the benefits intended for those for whom the hospital was founded and is maintained. It must also be remembered that special attention is being given to those requiring operations to enable them to enter the army. Let those who live by it enjoy the fleeting "Kudos" referred to by your correspondent; we have always stood on firmer ground. Of this I feel sure that did a great emergency arise, then would Guy's and Guy's men be second to none, in offering all they possessed.—Yours faithfully,

Sept. 28th, 1914. CHARTERS SYMONDS.

Dear Sir,—I have read with interest the two letters in your last issue signed Guyite and Old Guy's man, as well as your temperate editorial comment upon them. In my opinion no one of the three goes to the root of the matter, and since attention has been publicly called to the subject, it seems to me urgent that all the facts should be put before us, In order that we may decide whether or not it is *right* to dismiss our civilian sick,

we must first know whether or not it is *necessary* to do so. Has the governing body of our hospital refused an urgent patriotic duty, or has it rightly set its face against a movement which has affected nearly all other hospitals—a movement which, however laudable in intention, was conceived and executed in a moment of excitement, and which, while it has freely sacrificed the interests of the poor, has now proved to have been unnecessary, and therefore ill-judged?

It has been said—with what truth I do not know—that before a shot had been fired, as the result of the closure of beds in civilian hospitals all over the country and of the provision by private enterprise of beds in various private houses, convalescent homes, schools, and other buildings, the War Office found itself in the position to provide a bed for every fourth member of the Expeditionary Force. The offers of beds in civilian hospitals were, I believe, all accepted. Indeed, under the circumstances, the War Office could hardly refuse, so generously and freely were they pressed upon it. A danger, however, at once manifests itself. The wards were closed. They could hardly be allowed to stand empty. Those who had shut their wards to the poor might very well urge that their position demanded that wounded should be sent to them at as early a date as possible. I do not know whether this actually occurred, but it is significant that the first wounded to arrive in London were sent to civilian hospitals. Private houses, specially constructed hospitals, and military hospitals might, indeed, remain empty or half filled without glaring incongruity, but this could hardly be allowed where the poor had been ousted by the hundred to permit the offer to be made. In other words, before we can understand whether the Governors have done right or wrong, you, Mr. Editor, must tell us—

1. The number of hospital beds closed to the sick poor of London, and the percentage of such beds occupied and empty.

2. The number of other beds given to the War Office and approved by it for the reception of wounded and sick, and the percentage of such beds empty and occupied.

3. The number of beds in military hospitals occupied and the number empty.

When we have these figures before us, we can judge rightly of the action of the Governors of Guy's.

Your correspondents, however, and you yourself, Mr. Editor, base your appeal upon other grounds than that of necessity. It is suggested in the first place that by dismissing the sick poor, even although it is not necessary to do so, the hospitals may find their task of collecting funds for the relief of these self-same poor much lightened. I do not believe that this consideration prompted the action of the hospitals who have admitted wounded. The offer was made in a spirit of the most generous patriotism, and has not been a manœuvre to collect funds. In the second place, we are told that by admitting wounded soldiers we shall avoid any difficulty which may be anticipated in finding house-officers during the war. Guy's men have stood loyally by their hospital. Those who were free to offer their services immediately to the Admiralty or to the War Office did so at once and unhesitatingly. Those who held important posts in Hospital or School were careful not to embarrass the conduct of these institutions by rushing off in a body at a moment's notice, but have gone and are going in an orderly manner after assisting to make satisfactory arrangements for the carrying on of their work. I do not believe that the decision which each man must make, as to whether he goes or stays—and he does his duty in either case—would be made one whit easier for him by the presence of a number of wounded in our midst.

Finally, sir, and most wrongly of all, in my opinion, you urge that even if it be granted that our duty lies in another direction, some wounded should be admitted, in numbers at least sufficient for us to make a show in our talk amongst our neighbours. You would have us turn out the civilian sick and admit the soldiers, even although such action may prove to be unwise though generous. Just so, when the *Aboukir* was torpedoed, was the action of the captains of the *Cressy* and the *Hogue* unwise though generous. A pardonable error was, I think, the official verdict. The nation on all sides in recent days has had cause to repent one of its most attractive faults, an excess of sentiment which allows the dictates of the heart disastrously to overcome the judgment of reason. Sense, not sentiment, should guide our actions in times like the present, and let us, on that account, stand up to a little of the criticism of which you, Mr. Editor, make so much.

I leave on one side the question of the part which civilian hospitals might play and ought to play. The great majority of soldiers who fall out of the fighting line and are transferred to hospitals in this country until they can again be passed as fit for arduous and active service, require only rest and the simplest of treatment. Such cases, it might be argued, are not suited for admission to the great civil hospitals with all their wealth of resources. The aim of a military hospital is to restore its patients to the fighting line. So soon, however, as it becomes evident that this is impossible, the crippled and maimed must be discharged from the army. For many of these men the resources of civilian hospitals may do much to restore them to active civilian life.

The pressing need of the Admiralty or of the War Office could alone justify the request you make. If that need is made clear, I have no doubt that the beds will at once be forthcoming. If, at the moment, there is no need to sacrifice the interests of the civilian population further than has been already done, then surely the matter is settled. How come you then to urge the Governors to turn out the sick poor to gratify our personal feelings, and you do more, you say that your sentiments are universally shared by Guy's men. I protest it is not so.—Believe me, yours faithfully,

H. CHARLES CAMERON.

Sir Henry Greenway Howse.

Henry Greenway Howse was born at Lyncombe Hall, Lyncombe Vale, Bath, on December 21st, 1841. He was the second son of Edward and Isabella Howse. He was educated at University College School, and was apprenticed for a time to Mr. J. W. Workman, a medical man in Reading.

Entering at Guy's Hospital in October, 1861, he soon showed his great capabilities. He obtained the Second Prize for General Proficiency in his first year, and the First Prize for the same in his second year, while in this same summer of 1863 he carried off the Exhibition in an entirely different subject—Biology—at the Preliminary Scientific Examination of the University of London. In his third year he also gained the First Prize, and at the London University First M.B. Examination took the Exhibition and Gold Medal for Physiology, Histology, and Comparative Anatomy, and Honours in Anatomy. At the Final M.B. Examination two years later he obtained the Gold Medal in Midwifery, with marks qualifying for the Scholarship, and Honours in Medicine; and in the following year at the Examination for the Bachelor of Surgery he obtained the Scholarship and Gold Medal. A year later he took the degree of M.S., with marks qualifying for the Gold Medal. He held the Hospital appointments available in those days, was dresser to Mr. John Hilton, and subsequently House-Surgeon. I may remind my readers that in those days there were only two House-Surgeons. The Junior held office for two months, having charge of the surgery, of the venereal cases in Patience and Samaritan (not then known as Pat. and Sam.), and assisting his Senior if necessary. He lived outside the Hospital, but boarded in "the Rooms." The Senior had charge of all the other surgical wards under the Surgeons and Assistant Surgeons, boarded in the Hospital, and had two spacious rooms above the Dressers' Rooms.

After this Howse spent some time in Paris studying surgery. In 1868 he was appointed Demonstrator of Anatomy, his colleagues being Mr. Bankart, Dr. Pye-Smith, and Dr. J. J. Phillips. In the succeeding Summer Session he gave demonstrations on the use of the microscope.

At the retirement of Mr. John Hilton in 1870 Mr. Howse was appointed Assistant Surgeon, and in 1875 he became full Surgeon on the retirement of Mr. John Birkett.

As a lecturer and teacher, and as a practical surgeon Howse's characteristics were thoroughness in detail and a constant endeavour to improve upon existing procedures or methods. He laid the foundation of the pathological histological classes by himself cutting the sections with the razor at a time when the microtome was unknown or in its infancy.

In the dissecting room, where he was a demonstrator for three years, he conferred an enormous boon upon all students and demonstrators at and after his time by perfecting the method of injecting the subjects with disinfectant preparations. Up to that time a watery solution of arsenic was injected into the arteries, and this was followed by the red wax. Howse saw in glycerine a fluid which could be made to permeate the tissue by injection through the arteries, which would not evaporate as does water, and which was in itself preservative of animal and vegetable substances in contact with it. He made numerous experiments by injecting limbs and portions of limbs, and found that by this method the limb could be practically soaked in glycerine, and that decomposition was absolutely checked. To make doubly sure a small quantity of arsenic was dissolved in the glycerine, and this previous injection with glycerine did not prevent complete injection of the arteries with red wax. Modern students probably have little conception of the offensive state of the dissecting room as it was in the 'fifties and 'sixties, a discomfort and reproach which Howse's method entirely removed.

For a number of years Howse was editor of the Guy's Hospital Reports in conjunction with one of his colleagues. There are two sides to any venture of this sort, namely, the scientific or literary, and the business or commercial. Complete success requires attention to both. Previous editors had produced some most interesting volumes with valuable and important papers, but the financial affairs had been allowed to get into arrears, and Mr. Howse took an immense amount of trouble and showed a thorough capacity for business, in completely reforming this department with the aid of his co-editor.

But his great distinction was in the domain of his life's work—surgery, and this distinction was that he had an open mind towards Lister's work as it was reported from Scotland, that he

went himself to Edinburgh to see Lister in his wards, and that he introduced the antiseptic system, as it then was, into his own wards at Guy's Hospital, and was thus one of the first, if not the first, of London surgeons to follow in Lister's footsteps.

Howse was precisely the kind of man to succeed with such methods. Every modern surgeon knows that one essential in the antiseptic or aseptic method is extreme care and extreme attention to detail. Howse's frame of mind was exactly suited to this. Rather slow, deliberate, enquiring himself into every important matter, and not looking for immediate showy results, his patience and perseverance were amply rewarded. He had remarkable success in the treatment of tuberculous joints by excision, but the results of his numerous cases, which many of his colleagues hoped might have been published earlier, did not get into print until 1893, when they appeared in the Guy's Hospital Reports as a paper entitled, "On the Results of One Hundred and Thirty Cases of Excision of the Knee," by H. G. Howse, M.S. The Analysis of the cases by G. Newton Pitt, M.D.

In abdominal surgery, which had now become possible by the introduction of Lister's methods, Howse was naturally an early worker, and he obtained successes also in ovariotomy and in the treatment of varicose veins.

Howse was one of the surgeons first appointed to the Evelina Hospital for Sick Children, which was opened in 1869, and here he had good opportunities for the treatment of tuberculous joints.

As a teacher Howse was very successful; he had large classes attracted not so much by any eloquence or oratory as by the thoroughness with which he went into all his cases, his enthusiasm in favour of the comparatively new views which he advocated and the interest which he took in the education and progress of his dressers and clerks. And the fact that he was able to take round a large class at his visit every Saturday afternoon, and have a good attendance on Sunday morning, shows how highly his teaching was appreciated.

As a lecturer on Anatomy, on Surgery, and on Clinical Surgery he was successful in his clear exposition of the facts and in the valuable material he was able to put before his pupils, in spite of a not very perfect delivery.

There is another kind of work of which the student sees very little, but which has an important bearing upon the success of the Hospital and Medical School, and that is, the work of the Committees and Councils by which these institutions are managed. He was a valued member of such meetings, giving the most earnest attention to the business; his judgments were only arrived at after careful consideration, and were rarely other than thoroughly sound and trustworthy. He was thus concerned with most of the improvements in the School and Hospital which took place between 1880 and 1900, including the erection of Guy's Hospital College, which was due originally to Sir Cooper Perry.

Howse's retirement from the active Staff of the Hospital became due in December, 1901, but he was requested by the Governors to remain in charge a few months longer, and as Senior Surgeon he spoke on behalf of the Hospital's finances at a public meeting at the Mansion House on January 15th, 1902. In March of that year he became Consulting Surgeon.

Needless to say, that Mr. Howse took an important share in the proceedings of the Societies, especially the Royal Medical and Chirurgical and the Clinical, and having become a Fellow of the College of Surgeons, he was in due course appointed an Examiner, and later a Member of the Council, on which he sat for sixteen years. It was a great pleasure to all his friends, and an honour to Guy's, when, in 1901, he was made President of the College of Surgeons, and still more when he received the Honour of Knighthood at the Coronation of King Edward VII. in 1902.

If we consider his personal characteristics, I think we may say that he was persevering even to obstinacy, cautious and careful in all he did, and paying minute attention to detail, ingenious as a surgeon should be, perhaps rather diffident and slow to make acquaintances, but the very staunchest of friends. In habits and customs he was rather indifferent to the opinions of others, and somewhat careless of his personal appearance. For a number of years, when we were both resident in St. Thomas's Street, I was constantly consulting with him on various matters connected with the work of the Hospital and School, and when I look back upon those times I cannot recall a single instance in which his opinion could be said to be influenced by consideration for his own welfare, and in which it was not wholly and entirely formed in the common interest or in the interest of others. Nor do I remember him to have had any antipathy or anything but a kindly feeling towards any one of his acquaintance.

Howse was rather short of stature, but thick set and strongly built, and capable of much endurance. He was fond of reading and he occasionally played chess or whist; but these were not days in which Sunday golf or week-end motor rides were held to be necessities of our existence, and his outside recreations were few. But he threw all his recreative energies into his annual holiday, which for a number of years he spent in mountaineering in Switzerland. For six successive years I was his companion in these expeditions, and we were rather exceptional in making our climbs without the help of guides. Our sanity was sometimes questioned, but Howse had been well trained himself with guides in previous years. He was extremely careful in his preparations, studied well the routes in the mountain literature available, and was always willing to give up the chance of a peak or pass if the weather or other conditions were too strongly adverse. If we took longer about a climb than if we had had professional assistance, there were extraordinary compensations in the feeling of independence and the gratification of self-accomplishment, and our frequent successes were due entirely to his clever leadership.

While he was a student and during his early years on the Staff, Howse had rooms in Great Maze Pond close to the Hospital. When he became Assistant Surgeon he succeeded Mr. Cooper Forster in the tenancy of what is now 24, St. Thomas's Street, and in 1887 he moved to a large almost palatial residence, 59, Brook Street. On his retirement, or partial retirement, he took the Tower House, Cudham, Kent, but for the first few years he had consulting rooms in Grosvenor Street.

In the country life to which he had always looked forward he devoted himself to his garden and miniature farm, and had his own electric light installation.

In 1881, Howse married Miss Marshall, the daughter of the Rev. T. Lethbridge Marshall. She survives him with two daughters and a son.

Sir Henry Howse was generally strong and healthy, but he had a severe attack of jaundice during his house-surgeoncy which, however, he did not allow to interfere with the performance of his duties. Later he suffered from a bad poisoned wound of the finger, which left its mark upon him for life.

In Sir Henry Howse's later years he suffered much from osteo-arthritic changes in one lower extremity, by which ultimately he was seriously crippled. With an increase of this trouble, and with the continuous severe pain associated with it, he became exhausted, and sank on Tuesday, September 15th. The funeral took place on the following Saturday at St. Luke's Cemetery, near Bromley.

FREDERICK TAYLOR.

Papers by Guy's Men.

Kenneth Goadby, M.R.C.S., L.R.C.P.: Electrolytic prevention of lead poisoning.—*Lancet*, October 3rd, 1914.

John D. Malcolm, F.R.C.S. Edin.: Rupture of a Dermoid Cyst into the Cervix Uteri during delivery.—*Clinical Journal*, September 30th, 1914.

Lieut. G. B. Harland, I.M.S., M.D.: A note on the surgical treatment of Goitre in Tibet.—*Indian Medical Gazette*, September, 1914.

Lecpold Mandel, M.D.: Summer Diarrhœa: a résumé of the recent work done on its ætiology and bacteriology with some notes on treatment.—*Practitioner*, September, 1914.

Capt. D. P. Watson, and others: Description of a strain of Trypanosoma Brucei from Zululand.—*Journal Royal Army Medical Corps*, September, 1914.

Notices.

Guy's Hospital Medical and Dental School.

The following Entrance Scholarships and Prizes have been awarded:—

Senior Science Scholarships for University Students.—£50, John Maurice Hardman Campbell, New College, Oxford; £35, Frederick Alfred Unwin, King's College, London.

Junior Science Scholarships.—£120, Albert Ernes Sawday, Guy's Hospital Preliminary Science Class; £50, Sydney Anselm Sharpe, Guy's Hospital Preliminary Science Class.

Entrance Scholarships in Arts.—£50, Edward Emile Delisle Gray, St. Paul's School; £50, Myles Wheeler O'Bryen, Oratory School, Edgbaston.

Open Scholarship in Dental Mechanics.—£20, Alfred Herbert Bowes.

Scholarship in Dental Mechanics for Pupils of Guy's Hospital.—£20, Wyndham Brookes Farrington.

Bolingbroke Lecture.

The Bolingbroke Lecture for 1915 will be delivered before the South West London Medical Society on June 9th by Sir William Arbuthnot Lane, Bt., M.S.

Two Interesting "Take-In" Cases.

By J. G. SANER, M.C., F.R.C.S.

Case I.

Removal of Bullet from the Liver. Recovery.

Early in the year, February, a boy, C. J., aged 12, was brought up to the Hospital with the following history. While the headmaster was attempting to extract a bullet from a small rifle it went off, and after hitting a desk lodged in the boy's abdomen. The patient was brought up to the Hospital and admitted into Cornelius Ward.

On examination the boy seemed very happy and rather looked on the whole affair as a joke. X-ray examination showed the bullet just below the costal margin, moving slightly on respiration. There was a small circular wound at the outer border of the right rectus muscle, two inches below the costal margin. The edges were blackened and inverted. There were some strands of cloth in the wound. The boy was admitted at 5.30 p.m. in the afternoon; at 8.30 p.m. an examination showed his abdomen supple, movable, and not tender. His pulse was over a hundred.

His general condition appeared so good that it was thought that in all probability the bullet had not penetrated the peritoneal cavity or, at any rate, a hollow viscus.

Operation, 9 p.m.—An incision was made in a vertical direction through the right rectus muscle so as to include the wound. The track was cleansed down to the anterior layer of the rectus sheath which was then opened. The fibres of the muscle were split and the bullet found to have penetrated the parietal peritoneum, the general direction of the track being upward.

An examination of the peritoneal cavity showed no hæmorrhages or free fluid. The intestines were packed off and an examination of the anterior surface of the liver made. After some time an irregular crack, somewhat this shape *X*, was seen in the capsule. On grasping the edge of the liver between the thum and finger of the right hand, its substance could be palpated, and the bullet was felt in relation to its inferior surface, midway along the attachment of the gall-bladder. An attempt to remove the bullet from the inferior aspect was not made, as there was considerable difficulty in obtaining a good exposure. Moreover, it was thought advisable to follow the track of the bullet, as portions of clothing had already been removed from the abdominal wall. The bullet was located with the finger of the left hand. The edge of the liver was then firmly grasped between the thumb and the first finger and pulled down from under the costal margin. The area under compression became distinctly blanched.

An incision was then made through the liver substance on to the bullet felt at the tip of the first finger. The hæmorrhage was slight, and after a little manipulation the bullet was removed with a pair of dissecting forceps. Portions of clothing were also found around the bullet at a depth of an inch and a half. The incision in the liver was closed with mattress sutures after being treated with iodine. A drain was put down to the liver and the abdominal wall sutured.

Subsequently most virulent sepsis attacked the wound, which became foul and stinking. The sutures were removed where it was required, and on examination the liver was found exposed at the bottom of the wound.

At the end of a fortnight the sepsis cleared up, and the boy's pulse and temperature were normal. On the 20th day I was able to dissect up and suture the anterior layer of the rectus sheath on each side and close up the skin wound. On the 32nd day he was sent to the seaside with the wound healed.

Lately, he has been swimming in races with varying success. Examined towards the end of September there was no hernia. There was some atrophy of the rectus muscle to the inner side of the wound.

There were various points of interest about the case. The small amount of discomfort caused by the presence of the bullet in the liver was remarkable. The boy was particularly lively, though his pulse was steadily rising at the end of three hours, and his temperature just over a hundred.

The point of entry in the liver was difficult to find. The hæmorrhage from the liver was very small, though it was with some trepidation that an incision into its substance was made. The mattress sutures seemed to control it most effectually. The virulence of the sepsis following the operation supported the decision to explore and drain.

Case II.

Splenectomy for Torn Pedicle, followed by Intestinal Obstruction. Recovery.

On the 4th September, 1914, C. F., aged 8, was run over by a motor-car. An eye-witness stated that the wheel passed over his abdomen from left to right. The patient was conscious on admission. He had vomited. There was no blood visible in the vomitus.

On examination he was found to be lying on his right side. He was very white and almost pulseless. The abdomen was rigid and tender. On percussion, with the boy lying on his right side, the left flank showed a considerable area of dulness. There was also some dulness in the right flank. Ruptured spleen was diagnosed and the boy taken up to the theatre. Subcutaneous saline was given from admission into the ward.

On examining the patient when partly under the anæsthetic, it was found that the area of dulness on the left side had spread to the middle line and that the right flank was more resonant than when the boy had been lying on his right side.

Operation.—An incision was made through the left rectus muscle, and the peritoneum was opened. A large amount of blood was found extravasated, welling up from the left kidney pouch. The right rectus muscle was then cut across and the spleen brought out. The diaphragmatic surface was intact, and it was only on examining the pedicle that the cause of the hæmorrhage was found. The vessels in the lieno-renal ligament and gastro-splenic omentum were tied. This was by no means easy, and I am not at all sure that my ligatures caught the vessels involved. It seemed rather that the removal of the spleen after ligature of the vessels still intact allowed the torn vessels to retract and close naturally. During the operation, which was very hurried, there was no pulse at the wrist. The respirations, however, were regular and fairly deep, considering the condition. During the next few days, though extremely weak, the patient's condition gradually improved. There was some difficulty in getting the bowels open, though on the 3rd and 5th day following the operation enemata gave fair results.

On the 6th day he complained of some abdominal pain and was slightly sick. On the same day an enema gave a poor result. In the afternoon he vomited, bringing up some bright yellow material, non-fæculent, but distinctly from the intestine. I may state here that the vomitus on the previous day had been bilious. On examining the abdomen the distension seemed to have increased, and, on examining the surface, there was a general irregularity. The question arose as to whether the boy had peritonitis or intestinal obstruction, and it was decided to operate at once.

Subcutaneous saline was given, and the abdomen opened through the original incision. There was free fluid in the abdomen. Distended and collapsed coils of intestine were found, and when unravelled it was found that the obstruction was caused by an organising blood-clot fixing the gut under the right costal margin. This was freed, and the contents were pressed on to collapsed gut. The wound was sewn up with some difficulty. For a week following the operation he had a good deal of diarrhœa. The wound broke down. Suppuration has now ceased, and he is putting on weight.

It seems very rare for a portion of the hilum to be torn and the convexity of the spleen to remain intact. In fact, the absence of this tear made me almost decide to replace the organ. It was only on examining the renal surface, and so the lieno-renal ligament, that the torn vessels were observed.

The child's condition was extreme when the spleen had been removed and only a cursory glance was obtained of the splenic bed. However, at the second operation I was able to explore the fossa, and found that the ligatures I had employed were not in the position to control hæmorrhage from the vessels. From this one can argue that given a young case it is not absolutely essential to ligature off all the vessels and, in many urgent cases, it would be wrong to waste time. It is essential to cut away all splenic tissue so that retraction may occur. There was no necessity for this in my case, but it might arise in one where the spleen was macerated.

It is not common for intestinal obstruction to occur soon after an intra-peritoneal hæmorrhage, as it seems comparatively rare after cases of ruptured ectopic gestation. There was no doubt in this case that the clot had sharply kinked the lumen. The obstruction, however, was not of the most acute type in the mode of its onset.

Mr. Ballance in 1896 called attention to the following sign which was present in this case. If present it is pathognomic of splenic rupture. If absent it may still be that the spleen is injured.

"Though both flanks are dull on percussion, the right flank alone becomes entirely resonant on change of position. When the patient turns over to the right the fluid blood slowly drains to the lower side, but the clots which are found on all occasions are fixed and continue to reveal a dull note on percussion."

It may be remarked here that this is one of the rare—very rare—occasions in which abdominal percussion is of the slightest value in diagnosis.

Obituary.

Lieut. H. L. HOPKINS, M.D., R.A.M.C.

There must be many Guy's men who have a kindly recollection of Herbert Leslie Hopkins, who was killed "somewhere in France" on September 19th. With a view of bringing up to the time of his death the life history of one of the best of "Guy's men," the writer, who was privileged to become one of his intimate friends, has compiled these few notes of a career that promised much.

H. L. Hopkins, who was just 28 years old at the time of his death, entered Guy's in September, 1905, with an Open Scholarship in Arts. He obtained the M.B., B.S. Lond., in October, 1911, having also passed the Conjoint and the Primary F.R.C.S. In addition to the curriculum, he had filled the positions of Assistant Demonstrator in Anatomy and Physiology, Pathological Assistant to the Surgical Registrar, and had filled dresserships in all the special departments.

On qualifying, he determined not to go for the house appointments that would have fallen his way, but became House-Physician at Derby Infirmary. He filled this position for twelve months, during which time he came into contact with several old Guy's men. He then determined that Public Health was his sphere of action, and spent six months at the City of London Chest Hospital.

In August, 1913, he became Assistant M.O.H. and Assistant Inspector of Children to West Suffolk, and Clinical Tuberculosis Officer to the West Suffolk Insurance Committee. He was prevented from sitting for his D.P.H. Oxon. in May, 1914, but successfully obtained the M.D. Lond. (in State Medicine) in July, 1914.

A few days later, on the outbreak of war, he obtained a temporary commission in the R.A.M.C., and was at once appointed Sanitary Officer to Devenport Barracks. A few days later he was despatched to the front as Sanitary Officer to No. 11 Base Hospital, in which position his friends did not feel any great anxiety about him. Since his death the writer's family have received a letter in which he states that he has been attached to the 1st Devon regiment. Further details are at present impossible to gather.

Lieut. Hopkins was an indefatigable worker, with a large amount of business sense. His clinical knowledge was remarkable, and he was at the same time a good surgeon. His record in the public health service seemed to point to a highly distinguished career in the future.

A man of sterling worth, he achieved a solid popularity with those who met him, and he will be mourned by those who knew him in West Suffolk as sincerely as by his older friends.

H. E. H. T.

Reviews, etc.

Outlines of Zoology. By J. A. Thompson, M.A., LL.D. Sixth edition. 12s. 6d. net. (H. Frowde and Hodder and Stoughton.)

A new edition of Professor Thompson's "Zoology" calls for no detailed criticism. As a general text-book of Zoology it has long been known and appreciated by students for its clearness and conciseness.

Within the eight hundred pages an attempt is made to survey the whole animal kingdom as well as to give brief accounts of our present knowledge on such debatable subjects as Evolution and Heredity. It follows, therefore, that the treatment of the various subjects is necessarily very brief. A general "outline" such as is presented, is very useful to the elementary student in helping him to see the true relation of the selected "types" to the rest of the members of the animal kingdom.

The method of treatment will not recommend itself to students preparing for the first examination for M.B., the treatment of the types not being sufficiently full for that purpose.

It might be asked why Butschli's figures of Monocystis are given when much later ones are available?

R.

Some Experiences in Belgium during the German Invasion.

Our party consisted of the Duchess of Sutherland, eight trained nurses, and myself. We arrived in Brussels on the 17th August, and spent the night there. In the morning we took the train for Namur, but had to go round by Charleroi, as the main line had been cut during the night. This, as it happened, was the last train which reached Namur before the line from Charleroi was cut by the German cavalry. On arriving at Namur on the 18th, we heard that the station had been partly destroyed by a bomb that morning. Several more were thrown during the next three days, but they never did any great damage, beyond making a large hole in the street and filling the roadway with powdered glass from the houses round. They never succeeded in hitting the barracks at which they were aiming. We were given a large convent with 100 beds, and spent the next four days in turning it into a hospital.

On the morning of the 20th the forts, in which the Belgian staff placed great reliance, were attacked, and a regiment in the barracks opposite our convent went off in motors, amidst scenes of great enthusiasm, to the trenches in between the forts. The cannonade went on all day, and in the evening several soldiers came into the town with stories of the fall of one of the forts. Some were weeping, and all were in a great state of anxiety.

Early next morning, the 22nd, 5,000 French infantry passed through the town, and we all felt that the situation might be saved. At 7 a.m. the cannonade started again, and at 9 a.m. some Belgian artillery stampeded past our windows with no men to check them. At 2 p.m. the wounded started to arrive, and in less than two hours we had over 70 in bed. Altogether, during that day 110 wounded Belgians and Frenchmen were admitted.

During the whole of the morning of the 23rd the Germans shelled the citadel, which is obsolete and undefended, but was marked on their maps as a fort. The shells were shrieking over our convent up till 2 p.m. when the German infantry entered the town singing. These formed up in the market place and a great many civilians came out of their cellars to watch them. At that moment another force which had been attacking from the South and had come from Dinant, not knowing the town had fallen, began shelling again and dropped five shells in the midst of their own men, killing, as we afterwards heard, about 50 Germans and many civilians. We were all much too busy to go out and so I know very little about the behaviour of this first line of troops in the town; I think, however, it was on the whole good.

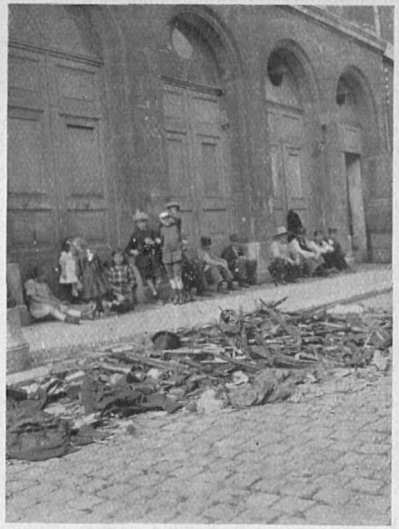
During all this time we were besieged at frequent intervals by batches of terrified civilians who were admitted to our vast cellars. Most of the nuns and all the novices had been there ever since the bombardment started, acutely conscious of, and anticipating again, the times of pillage and murder through which the convent had passed after Waterloo, first by the retreating French and later by the victorious Prussians.

That evening at about 8.30 p.m. we heard a fusillade of small arms in the town, which lasted about twenty minutes. We pulled down our blinds and put out all lights, as some of the shots were in our street, and thinking the French had come, we expected a tremendous battle. However, it stopped after about half an hour, and we were left in doubt as to its meaning. We were just going to turn in, at about 10 o'clock, when we heard the fire tocsin, and on going up into our old tower, we saw that the town was on fire in four places, all round us. Knowing that most of the houses were very old and made of wood we were rather anxious, but the night was so absolutely calm that although the firemen took two and a half days to extinguish everything, there was not much danger, and not more than 200 houses were burnt. If the slightest wind had arisen, the whole town must have been destroyed. Next day the Military Governor started a system of hostages. Five of the principal men from each street were taken and the Governor issued a proclamation stating that he would shoot the hostages and burn the houses of any street in which his troops were molested. After these stringent measures things were quite quiet, and we stayed in the convent until September 6th, when the Germans removed all our men who could walk as prisoners of war to Germany, and centralized the rest under German medical supervision in a large Jesuit college. Many of those I saw ought never to have travelled, and some, I think, must have died on the way. They treated their own wounded with the same heartlessness as they did those of other nations, and in fact looked upon them as a nuisance and a hindrance. With the Germans, at any rate, the end justifies the means absolutely in this war.

When our wounded had been removed we obtained a passport to go to Maubeuge on a military train to see if there was any work for us there. The train was a very long one and full of fresh troops from Germany who had decorated the carriages with the "Linden baum" before leaving the Fatherland. Whenever we stopped there was a wait of at least two hours, and the men would collect on the platform and sing their national songs. All the regiments are taught to sing and intone, and when marching, after each line of the chant, there is a pause of a certain number of beats, to prevent any interference with the breathing, and as the men have to count the beats, so their minds are involuntarily to a certain extent taken off their march and probable weariness. The fatiguing high notes that our Tommies reach in some of their popular tunes would never be allowed in the German army.

To continue our journey, on reaching Erquelines, eight miles from Maubeuge, we were told that a train had been destroyed on the line the day before and we must walk. This we did, having hired an old horse and cart for our luggage, and made our way past at least

A group of our wounded in the Convent, getting ready to go away as prisoners to Germany.



Arms taken from civilians' houses, Namur. They were broken and piled up in heaps.

The Market Place, Namur, guarded by German soldiers as some of the houses were dangerous to walk under.

A house visited by a German shell, on the way to Maubeuge.

Tommies wounded at Mons, with the Belgian Count, in whose chateau we found them very well cared for.

Type of German Reservist, who hates fighting.

Some Experiences in Belgium during the German Invasion.

15,000 French prisoners over the battlefield of two days before. The ground was littered with shell and cartridge cases, rifles and clothes; numbers of cattle killed by the shell fire lay about the fields, and every house and village on the way was looted and in most cases either burnt or destroyed by shell fire. We saw no peasants except in one house where they gave us some coffee.

When we reached Maubeuge, we found that it had suffered tremendously during it bombardment. We slept that night in a room with only three walls and glass all over the floor. The damage had been done by a shell which had utterly destroyed the hospital on the other side of the road, with great loss of life.

There was very little work to be done in the town itself as both armies had removed their wounded during the battle, so the Commander gave us a military motor, and next morning we started for Brussels. There I was arrested and taken to the chief "spy-catcher." A signed statement was taken in to him and he pronounced me harmless after a wait of about half an hour, during which I felt rather as though I was up for my Final Conjoint again. We stayed three days in Brussels and then obtained a passport for England, via Liege and Holland. I feel I must add, for the benefit of sufferers from sea-sickness, that though I have never even crossed the channel when choppy without being ill, and this was extremely rough, so much so that we very nearly waited till next day; having taken "mothersill," I walked the deck like an admiral, and in fact had a large meal when half way over. I get nothing (unfortunately) for inserting this, so they may be sure it is genuine.

As regards our cases in Namur: we had about 150 altogether, all Belgians and French, except about a dozen who were Germans. They were nearly all cases of shell wound, either caused by a piece of the shell, in which case the great bruising and tearing usually caused a large slough, or by the shrapnel bullet, in which case, though not always septic, the wound gave little trouble. We had two cases of men utterly unbalanced mentally by hours of bombardment in the trenches. One was haunted by an aeroplane which he followed with his finger, and the other was constantly wishing to shoot, and his pupils dilated with fear when the shells whistled over us. They both became much more restful with hyoscine than they did with morphia, and eventually recovered completely.

O. G. MORGAN.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

A Guy's Man in the Crimean War.

At the present time, when so many Guy's men are serving in the medical departments of our naval and military forces, the following extracts from letters of an old Guy's man who was an army surgeon at the time of our last continental war may be of interest. They well illustrate that maladministration and lack of organisation for which the Crimean War is notorious, and form a striking contrast to the accounts which we may expect to receive from our fellow Guy's men who are engaged in the present great campaign.

The organisation of the army medical service has now happily reached a high grade of efficiency, and the *status* of the army surgeon has been immensely improved, largely through the efforts of pioneers like the author of these letters—Surgeon-General Sir Thomas Longmore, C.B. At the time of the Crimean War he was Surgeon of the 19th Regiment. He was born in London in 1816, the son of a surgeon in the Royal Navy, and educated at Merchant Taylors' School. In due course he became a student at Guy's, and was dresser to Mr. Bransby Cooper, whom he assisted in private practice and in writing the life of Sir Astley Cooper. He arranged and catalogued the museum of Sir Astley, which was afterwards purchased by the Royal College of Surgeons. Longmore qualified M.R.C.S. in 1841, and in February, 1843, he was gazetted Assistant Surgeon, 19th Regiment. He served with his regiment in Jersey, Corfu, the West Indies, and Canada, and his experiences on foreign service are recorded in the letters which members of the Old Guyites' Club, unable to attend the annual dinner, were accustomed to send to the president. Longmore returned to England in 1851, and was promoted to Regimental Surgeon in 1854. He went out the same year to the Near East, and was not absent from duty one day throughout the campaign. He was present at the battles of Alma and Inkerman, at the capture of Balaclava, and at the assaults on the Redan.

The letters are written to Mr. Edmund Birkett, Longmore's contemporary at Guy's, and fellow-member of the Old Guyites.

Light Division,
Camp above Sebastopol,
Feb. 16th, 1855.

My dear Birkett,

I am sorry to say that the deficiencies which you supposed existed, and which the newspapers have described, in the medical arrangements and affairs of the army have not been exaggerated. Shortly after the battle of the Alma, I wrote home a very strong letter, which an uncle of mine published in the *Daily News* of Nov. 8th, 1854. I wrote at some length, it occupied nearly three columns of the newspaper. I regret I did not ask my brother to show you the letter. But it was not only after Alma,

it was long before in Bulgaria that I and others saw what must happen, badly appointed as we were in respect to transport and hospital equipment, and subject so completely to the caprice of the military authorities under whom we were acting. We did not know it would be so bad as it has been in the Crimea, because we did not know that we were to be deprived of all our ordinary hospital armament, limited as that was, on landing and taking the field. All my hospital boxes, etc., were left behind either at Varna, or in the transport which carried us to Kalamita Bay. I brought 2 small panniers, on a vicious brute of a pony which I could not get exchanged, and which was always the cause of trouble to me, and those contained all the surgical and medical stores I had for my regiment, excepting a few stretchers carried by the bandsmen. I have reported everything to the Commission sent out by the Duke of Newcastle. You must know that I am one of the troublesome Medical Officers of the Army. I and Watt of the 23rd run in couples. From the time we were at Devna to the present time, we have been constantly writing official letters, complaining, remonstrating, warning, and in short, as the military people call it, "Making difficulties" of every sort. We have equally written through our Colonel to the General Officers, and through the Staff Surgeons to the Head of our own Department. We could not have done so had we not been supported by the head "Medicine-Man" of our Division, Dr. Alexander, whose name has been often mentioned in the papers. I believe he has been the only independent man in his position—stating plainly and bluntly that the Regimental Surgeons have been without the necessary accommodation and medicines for the treatment of the sick. At Monastere I wrote such a letter about being without medical comforts for the hospital when it was full of cholera, and diarrhœa was prevailing—backed by my Colonel—that a general hubbub was created; my complaint, however, was proved to be "frivolous" by General Airey (now Quartermaster General), and shortly afterwards a friend who had been dining with Lord Raglan told me that he had mentioned to him something about there being "a screw loose" in the Medical Department of the 19th Regiment. I fear my prospects of promotion are done for, but that affects me very little, as I would rather remain a Regimental Surgeon than take promotion in the present system of Medical affairs. Dr. Hall appears to me to be a theorist—all his faith seems pinned upon the term and States—I have seen no evidence of his being a practical man. I cannot understand how he condescends to retain his office after the wigging he got from the Commander-in-Chief in General Orders. I am quite certain that had he *insisted* on our having in the field the necessary ambulances, etc., Lord R. dared not have faced public opinion and refused the demand, if he did, Dr. H. should immediately have left the position he must have well known he could not keep under such circumstances with credit to himself or the Department, or benefit to the sick and wounded. I am equally certain that had Dr. Hall exhibited the necessary method, energy, and firmness, we should never have been without our proper supply of medicines and medicaments in the Crimea, for you must recollect that along the march we were in communication with our ships and transports, and ever since the ports of Balaklava and Kamiesch have been opened we have been in constant communication with Constantinople and the Depots of stores at Scutari. Even so late as the beginning of the present month we could get hardly any medicines. To an urgent complaint on this head made by Watt, Dr. Hall wrote through the Surgeon of the Division, Dr. Alexander, that perhaps Dr. Watt had better try the use of charcoal; there was plenty of that. I must send you a copy of Watt's reply; it is rather satirical. But imagine when our hospitals were full of frost bites, scorbutic dysentery, and general emaciation and cachexia from overwork, want of food and clothing, and all kinds of exposure—fancy his coolly sending to a regimental surgeon to "try charcoal." We are getting rather better now, for we have better allowance of rations, some vegetables occasionally, and a greater proportion, though still scanty, of fresh meat. The French, by taking the right, have diminished the labours of our men, who had dwindled down to a number totally inadequate to the work. Some few huts have been erected, also, and on the whole things are "looking up," as they say in the markets. But "nos numerus sumus"—we are now a mere handful. Out of my own poor remnant of a regiment I have already this month sent 100 invalids away, and I have this day 64 sick in the field hospital, chiefly scorbutic affections. We have less of the fearful mental and bodily prostration than we had during January; such cases of utter degradation of the *visvitæ* as we had during that month I trust I may never witness again. I never read or heard, much less witnessed, anything approaching to it.

General Sir G. Brown has joined us again, to my regret, for though a bull dog in courage, he refers everything to the peninsula standard, and wants all the qualities I consider most essential to a good general officer.*

He always stood in the way of every sanitary improvement in Bulgaria. I cannot give you a better illustration of his character than the following anecdote:—He was wounded in the arm on the 5th November, and has since been away from camp, either on board ship or at Malta. He saw the regiment three days ago, and about the first question

* "The most unbending opponent of innovations was Sir George Brown."—*Kinglake.*

he asked our Commanding Officer was whether he had pipeclay? The Major in command replied that he had not, and on further enquiry that there was none to be got at Balaklava. "Well," said Sir George, "it must be got from England; get your belts clean then the men will think of cleaning themselves." Not a word about the *means of ablution* and *personal cleanliness*, one of our greatest difficulties. Our only water is got from very small streams issuing out of springs in the ravines. The men bring, with great labour, enough for cooking up to camp. From only one set of flannels having been issued to the men until lately, when a second set was given, from their constant labour, utter fatigue and prostration, and always lying on the muddy ground, their underclothing became infested with a species of vermin, different in some respects from the ordinary pediculus, they multiplied in immense numbers, and the more anæmiated and prostrate the man the greater the increase of the parasites. We have done all we could to arrest the evil, but without washing tubs, bathing place, drying place, with snow on the ground and no protection but a tent, it has been impossible to prevent it altogether. Men threw away their flannels, abandoning all hope of ridding them of their swarms. You would not credit if I were to describe what living tissues I have seen some of these woollens become. Very few officers were at one time, before we got our baggage from the transports, free from some of these companions; and even at this moment no means are arranged for washing even our hospital blankets. I long since suggested the conversion of two houses or sheds at Balaklava, one into an ablution, the other into a drying-house, for hospital blankets, etc., but nothing was done One of our great difficulties is still to obtain for the men the time and means of personal cleanliness. Sir George Brown proposes to effect this object by pipeclaying the belts and *appearing clean*—perhaps the reality of cleanliness may follow.

Remember me to Mr. Cock-Gallaway and my other friends at Guy's. Watt also desires to be very kindly remembered.

Very truly yours,
(Signed) THOS. LONGMORE.

P.S.—I am sorry to say you will have to pay postage for this scribble, as I cannot get stamps—the post office has no heads, the other departments seem to be no better off.

The plague of lice here mentioned is described in detail in a later letter :—

Camp above Sebastopol,
March 29th, 1855.

My dear Birkett,

I received your letter of the 9th instant to-day. I write a hasty line to let you know that I have sent you two packages of the veritable Crimean Pediculi. I don't know whether they will survive the voyage, but perhaps they may, and they may then be of some interest, perhaps, as evidence before Mr. Roebuck's Committee. They are not likely to multiply and spread among you clean people in London, as they seem especially engendered by dirt and neglect. They infest the woollen clothes first, afterwards the person, and have no particular fondness for those parts of the body covered with hair. (When a man has had the head, etc., infested with vermin, as well as the clothes, the lice have been distinct in species.)

The lice so much talked about in the Crimea are of the same family, I believe, as those which infested our troops in the Peninsular—at least an old Peninsular officer told me so. The pediculi I send you were as common and seemed to thrive nearly as well on the ground for some time as on the clothes, and the officers, who had to lie down in the trenches, where also the men were in the habit of lying, got them in this way in considerable numbers every time they went on duty in the trenches. They multiplied with marvellous rapidity in the clothes and persons of men who became anæmiated and much debilitated, and the increase of vermin, and increase of debility, by mutual co-action, went on at least at geometrical ratio until death carried off the man. Putting wet flannels for a couple of days in snow destroyed the lice, but not the ova, and it was very difficult to get rid of them, as we had no means of boiling or baking the clothes. The larger lice burst from the effect of the cold when placed in snow, others became shrivelled up.

Here is an epistle on rather a curious subject, and you should have witnessed the surprise of a military friend of mine who took up one of the small parcels directed to you when I announced to him the contents.

The pediculi, when packed up, were alive and seemingly thriving; they are still tenants of their native flannel, and are stowed away not so tightly as to interfere with their comfort in two empty match boxes. To obviate any chance of escape, I have carefully pasted them up with a covering of white paper, more particularly out of consideration to Watt, who is the bearer of them to you.

Believe me,
Very truly yours,
(Signed) THOS. LONGMORE.

The following extract is interesting as showing how much a regimental surgeon could have taught the War Office authorities with regard to hygiene in soldiers' clothing, if only they had been prepared to learn. It has been left to our own time to see Whitehall consulting the physiologist in these important matters :—

Camp before Sebastopol,
April 1st, 1855.

. . . . . You fancy we Army Doctors have much more power than we have. The use of the Stiff stock has been remonstrated against for years—

was particularly objected to in Bulgaria—and common sense as well as physiology oppose its use. It may be useful to old men to support the head—the Duke of Wellington was compelled to wear several stiff rollers round his neck of late years with this object, but it is most objectionable for troops on the march or engaged in active exertion. But what avails one writing or speaking? Sir G. Brown has ordered the Commanding Officers of his Division to procure them for the men immediately, and I presume if you enquire of the Army Clothiers you will find they have been sent and are already on their way to us. So with the Chakos—they are to be restored at once, and the men who have lost them are to pay for new ones—rather a hard case, for they were ordered not to wear them in the early part of the Winter, as the height and brass ornaments made them conspicuous objects for the Enemy's riflemen when they went into the trenches. They had no place to put them, and usually stuck them on their arms as they were piled in front of the tents. The wind took some, and from various reasons, in the end all were lost. The French leave their Chakos at home, and bring into the Field a neat, light, and easy casquette. But all this will be remedied *by and bye* I suppose.

We are still not free from War Office red tape, but how serious an obstacle it was in the fifties appears from the following:—

Camp Sebastopol,
October 4th, 1855.

. . . . I sent away five Invalids to-day to England, Chatham, I suppose. I will send you notes of one or two of the cases next mail. I have had twenty-four Documents to write out with these five men! *One* for all practical purposes should have been enough.

After the Crimean campaign, Longmore received the medal and three clasps, and the Turkish medal. He served with his old regiment in the Indian Mutiny, until appointed Deputy Inspector-General of Hospitals in 1858. After his return to England he was, as we have seen, appointed to the professorship of military surgery.

In 1864 he represented this country at the international conference which drew up the first Geneva Convention, by which the care of the wounded in time of war was regulated until the new Convention was made in 1906. Longmore represented his country at several later international conferences, notably at Berlin in 1869 at a congress on aid to the sick and wounded in war. About the year 1870 he trained the first bearer company ever known in England, and he promoted the beginnings of the Red Cross movement in this country which many years later, in 1905, resulted in the formation of the British Red Cross Society.

Longmore contributed many papers on military surgery and on army medical administration generally, and he also wrote several treatises on these subjects. His work on "Gunshot Injuries," first published in 1887, may be described as a classic. A recent author* on the same subject describes it in these terms: "Of the excellence of this book military surgeons of all countries are fully aware. It is a book of reference all over the world, and its authority is quoted in almost every treatise that has been written on the subject since its first publication."

Sir Thomas Longmore's life of valuable public service received recognition in many honours, including the C.B. in 1867, and the rank of officer in the Legion of Honour. In 1868 he was gazetted honorary surgeon to Queen Victoria, by whom he was knighted in 1886 at Osborne. His portrait by Sir George Reid, R.S.A. was presented to the army medical department, and hangs in the anteroom of the mess-room at Netley.

A. N. C.

I am indebted to Lady Longmore for copies of the Crimean letters quoted above, and for the records of the old Guyites and other biographical details. Other works consulted are Kinglake's "The Invasion of the Crimea," and the recently published "Life and Letters of Sir John Hall (principal medical officer during the Crimean campaign).

In Namur during the Bombardment.

From the *Manchester Guardian*, Tuesday, October 6th.

Our Northwich correspondent has had an interview with Miss F. E. Ford, of Middlewich Road, Northwich, one of the Duchess of Sutherland's party of nurses just returned from Namur, where they had a nerve-racking experience. They were housed at the Convent of Notre Dame, which was fitted up with 100 beds, and arrived there on August 17. The actual bombardment began on August 21, and the shells poured into the town the night long. It was so terrifying that the nurses spent the night lying on flour bags in the cellar. The next day, however, 100 Belgian and French wounded were brought in, and, added Miss Ford, "it was not so bad when we were busy."

Proceeding, she said:—"It was a truly terrible Sunday, shells shrieking all the day long. Meanwhile, the Germans had thrown bridges over the Meuse, and towards evening they entered the town, singing as they marched. There were many rumours as to why Namur fell. I only know that it was very quick work. The French arrived on the Saturday, while the town was being bombarded, and they seemed very crestfallen. The way the Belgians kept asking us 'Where are the English?' was very pathetic.

"The Germans came to the convent on the Monday and informed us that all our patients were prisoners.

* Col. Stevenson: "Wounds in War" (1910).

They were really very considerate to us. That day civilians were accused of shooting at the Germans, and as a reprisal they set fire to the town in many different places. They were most terrible fires. The Hôtel de Ville was burned down and the whole of the Market Place gutted, the Germans themselves having finally to blow up the Hôtel de Ville to check the conflagration. The Market Place was quite near to the convent, and some of our windows were broken by the heat. For three or four nights we sat up to see that the convent did not get on fire, and we were prepared to transfer the wounded to a fire-proof wing.

"We remained a fortnight after the German occupation, and were then informed that those of our patients who were well would be taken to Germany, and the remainder would be transferred to the military hospital. The Duchess and her staff were then given passports to Maubeuge, and for two days and two nights we travelled in a military train to within nine miles of Maubeuge. This was as far as the train could go, and we placed our luggage on a cart and walked the rest of the journey. We entered Maubeuge on September 9th, and found that it had been taken by the Germans on the 6th. We were told that two hospitals had been destroyed; certainly we saw one which had been bombarded. At the station where we left the train we saw many English prisoners, of whom some came from Cheshire, and one boy told me that he came from Runcorn.

"The German commandant advised us to leave Maubeuge, and we obtained a motor ambulance and went by Valenciennes, Amiens, Tournai, etc., not to Ostend as we intended, but to Brussels. We were continually being held up and our passports examined, but on the whole we met with courtesy. Of course, we crossed the battlefield and the trenches, saw many big guns and endless trains of transports. The dead horses and cattle on the battlefield were a terrible sight, and the little mounds showed where soldiers had been buried. It was perhaps because of what we had seen that when we got to Brussels we found much difficulty in getting passports. The American Consul came to our aid, but for twenty-four hours we were not allowed to leave the hotel, and day and night an army seemed to be passing.

"We had had no news since we left England, except the reports which the Germans circulated of great victories all along the line. One story was that the Germans had taken Antwerp with 40,000 prisoners. During our journey from Namur we saw village after village absolutely burned out. The scenes of destruction were terrible, and the newspaper reports have understated rather than overstated the havoc."

Pass List.

Conjoint Examination.

The Royal College of Physicians and the Royal College of Surgeons, at their meetings on September 24th, conferred Diplomas of L.R.C.P., M.R.C.S., upon the following candidates:—

F. B. Bull.
B. Burnside.
P. R. Chevreau.
J. S. Cocks.
M. de Costa.
E. de W. Gibb.
R. W. P. Jackson.
H. L. Messenger.
L. R. Pickett.
C. H. G. Penny.
E. C. W. Starling.

MEDICINE.

R. C. Matson.

MEDICINE AND MIDWIFERY.

L. S. Fry.
J. E. Davies.

MEDICINE AND SURGERY.

J. H. Parry.

SURGERY.

C. H. Medlock.
L. Horsley,
S. S. B. Harrison.
G. L. Attwater.
S. Wilson.

SURGERY AND MIDWIFERY.

E. C. Cline.

MIDWIFERY.

L. A. Graham.
D. C. Scott.
H. L. P. Peregrine.
D. O. Richards.
A. H. Taymour.

Royal College of Surgeons, L.D.S.

FIRST PROFESSIONAL EXAMINATION.

G. W. Allen.
*H. J. Barrand.
A. H. Bowes.
*E. G. Browne.
*C. R. Cade.
*L. H. Dixon.
†B. Eady.
F. K. Escritt.
†J. A. Evans.
W. B. Farrington.
†G. F. Faustmann.
E. G. Foulston.
*F. L. H. Fox.
P. Green.
D. B. Hitchings.
C. H. Kidner.
*O. O. Lloyd.
H. O. Long.
*L. A. Morris.
*F. D. Neal.
*A L. Payne.
Stanley J. Peatfield.
†H. M. S. Pillow.
*J. C. Robertson.
*S. Sanders.
†H. M. Smith.
*C. S. Southwell.
I. M. Thomson.
†P. A. Tucker.
M. H. Wermig.
*L. G. Whelpton.

* Mechanical Dentistry only.
† Dental Metallurgy only.

Appointments.

Naval.

L. Mandel, Temporary Surgeon to the *Vivid*, additional for the *Donegal*.

F. G. Lloyd, Surgeon, H.M.S. *Victorian*.

H. Parry-Price, Surgeon-in-Charge, H.M.S. *Sheldrake*, Torpedo Boat Destroyer, 2nd Flotilla.

T. Norman, Temporary Surgeon, H.M.S. *Pembroke*.

Hildred B. Carlill, M.D., Surgeon, H.M.S. *New Zealand*.

C. H. Medlock, Surgeon's Dresser to the Fleet.

G. Hamilton, M.B., Temporary Surgeon, H.M.S. *Victory*.

A. H. Cook, Temporary Surgeon.

Royal Army Medical Corps.

To be Temporary Lieutenants: F. S. Brereton, late Capt., R.A.M.C., T. E. A. Carr, A. H. Birks, G. F. Hardy.

To be Lieutenants (Special Reserve): R. P. Ballard, M.B., B.S.; T. B. Heaton, M.B., B.Ch.; G. T. Mullally, M.B., B.S.; J. A. Ryle, M.B., B.S.; R. C. Ozanne, M.B., B.Ch.

To be Captain: A. V. Maybury, 3rd Wessex Field Ambulance.

Col. R. H. Luce (T.) to be Assistant Director of Medical Services, 2nd Mounted Division. Headquarters, Goring.

Lieut.-Col. W. G. Beyts, R.A.M.C., to hold civil medical charge of Rurki, in addition to his military duties, *vice* Lieut.-Col. A. W. Dawson, I.M.S.

To be Cadets, R.A.M.C.: W. J. McB. Allan, K. F. McAlpin, H. P. Parkes.

Indian Medical Service.

Major A. Miller, I.M.S., M.B., F.I.C., has arrived home on furlough from Madras.

Capt. P. S. Mills, I.M.S., took over charge of the Ambala Jail from Lieut.-Col. D. T. Lane, I.M.S., on 15th June.

Capt. M. A. Rahman, I.M.S, has been appointed a Specialist in Diseases of the Ear, Throat, and Nose.

Colonial Medical Service.

Mr. N. A. D. Sharp, Medical Officer, Gold Coast, has been transferred to Nigeria.

Civil.

A. K. Beaumont, L.R.C.P. Lond., F.R.C.S. Edin., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshops Act for the Uppingham District of the County of Rutland.

C. E. Bartlett, M.R.C.S., L.R.C.P., to be District Medical Officer of the Chepstow Union.

Births.

KENNARD.—On September 25th, at Bedford Square, W.C., the wife of Dudley Kennard, F.R.C.S. (née Hoffmann), of a son.

SYMNS.—On the 21st September, at Bungay, Suffolk, to Dr. and Mrs. J. L. Symns, a daughter.

Death.

GRACE.—On September 15th, at Springs, Transvaal, Gerald Grace, L.R.C.P., M.R.C.S., L.M.S.S.A., in his 48th year.

Nursing News.

Matron's Office.
7th October, 1914.

At little more than twenty-four hours' notice six more Guy's Nurses joined the Civil Hospital Reserve by request of the War Office. They left the Hospital to-day, October 7th, to report themselves at Southampton, and to be attached to No. 14 General Hospital, British Expeditionary Force. The party consisted of:—Nurses F. A. Spedding and M. A. Dodson, Guy's Institution; Mrs. Grundy (*née* Ball); Nurses I. Keeble, W. Evans, and M. Parsons.

There are now between 70 and 80 Guy's Nurses serving abroad in connection with the war. Among names not already reported to the Gazette are:—

At Paris.—With the Duchess of Westminster, Mrs. Hill, one time Sister Charity; Sister Evelyn, one time Assistant Matron: Nurse J. E. Hughes.

British Red Cross.—No. 4 unit. Nurses R. Leggoe, R. Masters, and E. Molesworth.

St. John's Ambulance.—Belgium Red Cross. Nurse N. S. Worsley.

British Red Cross.—Dieppe. Nurse Florence Broome, Guy's Institution.

At Havre.—Nurse D. M. Drew.

Q. A. I. M. Nursing Service.—Nurse M. Corbishley, Sister G. E. Custance, Sister L. Jenkins, Assistant Matron, Royal South Hants Hospital.

With Private Hospital Abroad.—Nurses M. Millar, M. Illingworth, and E. M. Cooper.

In the spring the Matron visited Nurses De Laveleye, A. M. Fletcher, and M. van Weddingen, at the Institut Moderne, Ghent. No news has been received from them but, owing to their situation, they must perforce be busy.

From all our people petitions come for letters and news. Daily and illustrated papers are in great demand.

At Versailles, in a large hotel and in tents around, most of our August 17th party are working very hard. They write of a 1,000 beds, medical and surgical, a theatre, unprecedented "take ins," and long hours.

The work on "station duty" and on the hospital ships is very arduous.

It is sad to hear of the wounds being in such awful condition before the men can receive attention and of the prevalence of tetanus.

One Sister writes of the contrast between the Park at Versailles—"a beautiful place; the trees, lakes, and flowers are perfect, and then the disgusting, revolting war which seems more and more to be the most intensely wicked form of insanity that attacks human nature."

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

"I wander through each chartered street,
Near where the chartered Thames does flow
A mark in every face I meet,
Marks of weakness, marks of woe."

WILLIAM BLAKE.

NEVER was London more dull than at present. The gloom of dimly lighted streets added to the usual October mist, the ever muddy footpaths, fill us with an unhealthy misery which is reflected on the motley crowd hurrying across London Bridge for a few brief hours' respite from the rush and roar of toil in the great city. In this mood, conscious of a missed opportunity, the task of writing these innocuous pages is commenced. Why should these pages be so innocuous? This thought increases the feeling of utter incompetence. The present is a time for action, not words! But if a philosopher could guide this pen, a ray of happiness, of hope, of comfort, might be sent to every reader of the GAZETTE.

We may make an excuse and say that the pessimist is never a philosopher because the basis of pessimism is dogmatic. Assuming, as we may safely do, that such a truculent statement is quite untrue, it cannot be denied that the ideas of the pessimist, like those of Prussian Imperialism have no broad outlook for mankind, and so they must ultimately be crushed. There is no set division of the world into optimists and pessimists. Every mind is unsettled and fluctuates between hope and gloom. Despair is a necessary foil to happiness.

"No matter where, of comfort no man speak.
Let's talk of graves, of worms and epitaphs;
Make dust our paper, and with rainy eyes
Write sorrow on the bosom of the earth."

Even the philosopher is helpless, he cannot alter the ideals of mankind. He may quibble over the definition of duty or of freedom. But animal instinct existed before philosophy, and from animal instinct, by a struggle through the ages, national character has been evolved. As Biologists we recognise that the fundamental characteristic of life is lability, a response to external stimulus. Lability is destroyed by captivity, the unfettered forms of life are the most highly developed. The basis of the character of mankind is partly physical, partly intellectual, partly spiritual. It cannot be entirely physical, entirely intellectual, or entirely spiritual. These higher characteristics of life depend for their development upon a freedom of action and thought for every living being. Force, intellect, and religion are inter-dependent. A national character is recognised according to which of these ideals predominates.

Of these ideals force is the most primitive. A survey of the history of the world soon convinces us that the doctrine "might is right" has already been doomed by evolution. Great Britain is a great nation to-day because experience has taught her to respect her Colonies and allow them to live their own moral and religious life without interference. A failure to recognise the primitive instinct of free thought and action caused us to lose America in 1770. The sacrifice was profitable, for it gave us a

national imperial ideal. India, Egypt, and South Africa govern themselves. They live their own lives under the guidance of the Mother Country. This brief survey enables us to judge the present struggle for the survival of what is best for mankind with an unbiased mind. Our unhealthy pessimism is destroyed. We have ceased to be dogmatic.

"Above all rivers, thy river hath renowne . . .
O! towne of townes, patrone and not compare;
London, thou art the flower of cities all."

Dunbar.

We are now opposed to the greatest fighting machine in the history of the world. The ideal of Prussian Imperialism is a world empire founded by the sword. The world is then to be compelled to recognise the dominance of German art, German science, German culture. This master stroke in the lust for world power, physical, moral, intellectural, finds us unprepared.

Let us recognise that this very unpreparedness is our source of strength. It shows that the doctrine of force has no place in our Imperial ideals. The price we have paid for our allegiance to the natural evolutionary principles of human betterment is a very heavy one. Belgium and the South of France are ruined, desolated. Our army retreated in what the pessimist said was a rout. They forget that Prussian Imperialism is a machine lacking human lability. They forgot the one imperishable law of nature—supporters of the divine law of freedom for human thought and human action were bound to succeed in the end, however far distant the end may be.

We are now on the eve of the final overthrow of force and brutality as a part of an Imperial ideal. Thus, when sorrow lays a heavy hand on us and we grieve for the loss of a dear friend or colleague, let us remember that nature exacts a heavy toll for human progress. All honour to those of our countrymen who have fallen for a cause which will make the world better and brighter for our children and grandchildren. Russia has at last freed Poland and her own people from ignorance and oppression. German art and German culture will take their just place when loosened from the yoke of Prussian brutality and false philosophy of self aggrandisement.

Among the officers mentioned in despatches by Sir John French appear the names of three Guy's men. Captain M. Leckie, at present a prisoner of war in Germany, Captain A. C. Osburn, and Lieut. H. L. Hopkins, killed by a German shell.

Surgeon L. C. D. Irvine, R.N.V.R., who was saved from the ill-fated *Hogue*, has now been appointed to H.M.S. *Pembroke*, additional for H.M.S. *Cornwallis*. Guy's men, especially Rugby Footballers, will hear with regret that J. H. D. Watson was aboard the "Hawke" when she was submarined. He was at the London Hospital last season, and played with great distinction for England, Blackheath, and his Hospital. We tender our sympathy to his relatives.

A Guy's Infantry Company in connection with the University of London Officers' Training Corps is now in process of formation, and consists, at present, of about 35 men. The membership of this company is especially applicable to men in the dissecting-room, dental men, and any ward men who prefer combatants to army medical work. At present weekly drills are held on Monday and Saturday afternoons from 3 to 6, at King's College, Strand. Application forms, etc., may be obtained from Mr. F. Bocquet Bull, at the Residents' Dental Officer's room.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—Might I suggest, in view of the decision of the Governors, that the motto under the Guy's crest (of which all old Guy's men are so proud) be altered from "Dare Quam Accipere" to "Business as usual."

—Yours faithfully,

Granville House, C. EDWARDS.
Bridport,
October 5th, 1914.

Note on the Use of Picric Acid for Sterilising the Skin.

The antiseptic action of picric acid has been long known, its most frequent use being as a dressing for burns. Recently it has been suggested that it should be employed for the purpose of sterilising the skin before operations, and I have now systematically used it for this purpose for three or four months instead of an alcoholic solution of iodine. The results have been most satisfactory, and I have come to the conclusion that it is quite as effective as the iodine method of preparing the skin, and in several ways is superior to the latter. It has been used for all kinds of cases, both for acute cases which have called for immediate operation, so that the entire preparation has been carried out on the operating table, and for cases which were not urgent in which the preparation of the skin was made in the ward before the patient was brought to the theatre. The method adopted has been similar to that employed in the iodine method, a 1 per cent. solution of picric acid in methylated spirit being substituted for the alcoholic solution of iodine. Thus, in urgent cases, as soon as the patient is anæsthetised the skin is shaved and dried, then treated with ether or iodine, and finally thoroughly painted over with the picric acid solution. When the preparation can be carried out at leisure in the ward, the skin is shaved and is thoroughly cleaned with nail brush and hot soap and water; it is then dried, treated with ether, painted over with the picric acid solution, and finally covered with a sterilised pad which is bandaged in position. After this compress is removed in the theatre, a second application of picric acid is made before commencing the operation. The results obtained with picric acid have been extremely good, suppuration in cases not previously infected having been very rare. Indeed, I can only recall two cases—a radical cure of inguinal hernia in a child and an exploratory laparotomy for an inoperable growth in a cachectic woman in whom the operation was followed by suppuration in the abdominal wall. In neither of these cases can the suppuration be attributed to imperfect action of the picric acid solution.

The advantages of the picric acid method are as follows:—

1. It is much cheaper than an alcoholic solution of iodine. This is shown by the following figures which have been kindly supplied by Mr. Finnemore. Before the war the cost of iodine was 13/7 per lb., while the cost of picric acid was only 2/- per lb. Since then the price of both has risen considerably, that of iodine especially having practically doubled. In addition to the iodine, potassium iodide at 11/2 per lb. (now greatly increased) is necessary to dissolve the iodine and preserve the solution. The respective cost of methylated and rectified spirit is 2/6 and 27/-. Thus when the cost of a 1% solution of picric acid in methylated spirit and a 3% solution of iodine in potassium iodide and rectified spirit are compared, it is seen that the former is much cheaper.

2. The picric acid solution is less irritating than the tincture of iodine. I have had no case of dermatitis after picric acid, and the patients do not complain of the burning sensation that is sometimes experienced after the application of iodine.

3. It is claimed that the picric acid solution penetrates more deeply into the skin than the iodine solution, and is thus more effective in destroying organisms in the deeper layers of the epidermis and in the sweat glands. I am inclined to think that there is some foundation for this claim.

The only disadvantage is that picric acid stains the skin a bright yellow colour, which does not disappear for some weeks, while the yellow stain of the iodine quickly goes. Possibly this more permanent staining is due to the greater penetration of the picric acid. The solution has no deleterious action on towels, mackintoshes, or rubber gloves, though if these are not worn the operator's fingers will be stained.

I certainly think that there is a very wide field of utility for this solution of picric acid not only in the theatres and the wards for preparing the skin for operation, but also in the front surgery and minor operation rooms, where it would be equally effective as the more expensive materials at present in use. For instance, lacerated fingers, scalp and other wounds, compound fractures, and such like injuries might have the skin treated in this way in the front surgery before they are admitted to the wards for operation.

I believe that one of the reasons for the great advance in price of iodine is that such large quantities are required by the Government for use in field and other hospitals. We have all heard of the septic character of the wounds in patients transferred to the base hospitals in

England, so that perhaps some Guy's man who has the opportunity might try the effect of treating bullet and shell wounds from the first by painting the skin around with picric acid solution in the way I have indicated.

PHILIP TURNER.

Obituary.

ALBERT EVELYN FAIRFAX KYNASTON.
Died October 13th, 1914.

Ever careless of himself and his own interests, always thoughtful of others; such was Evelyn Kynaston. To the superficial observer he was the most superficial of men; those who got beneath knew that he had deep-rooted convictions. Put forward in the form of a joke or expressed as a matter of course, he lived up to them. The old ladies of the infirmary loved him, the malingerer or tired worker got little change out of him. A colleague might ask him to change his time-off, and would learn a week later, or never at all, that he had put off a dinner and a theatre for it. He would have shared his last halfpenny with a friend, or have tossed for it at the nearest corner.

He entered Guy's in 1899, and taking the London University course qualified M.R.C.S., L.R.C.P., in 1904, but never took his degree. He had been meaning to go up for it every six months for the last eight years; but the weather was fine and the fresh air good, or the weather was bad and the infirmary busy, so it was put off from time to time, but never seemed to matter for he was not a day older than when he qualified.

He played every imaginable game very tolerably well, and knew the career even of those who "also ran." His skill with the cue testified to more than an hour in "the coolest place in London," and he always attributed his failure to get Clinical to his known prowess with this instrument. He refused to apply again as one whom he particularly despised had got it over him, and he thought that if such men were given it he could find a better job; so in 1907 he went to the Poplar and Stepney Sick Asylum, where he stayed till the war broke out. It was there the writer got to know him, and there that everyone who worked with him got to love him, though had a word of such sentiment reached his ears he would have fled the place at once.

In the first week of the war he joined the Royal Naval Reserve, and was sent to H.M.S. *Devonshire*. His end was like his life, he was taken ill, pooh-poohed it, and went on till the fourth week of an attack of enteric; pneumonia compelled him to go into hospital and he died, aged 33, on the 13th October, at Dunstaith, on Cromarty Firth, where he was buried on Wednesday, October 14th, at the Dunstaith Naval Cemetery.

Notices.

Charles Oldham Prize in Ophthalmology.

This prize, which is of the value of £30, will be awarded in June, 1915. Candidates must have completed twelve months' ward work, and must, at the time of entering their names, be unqualified.

The examination consists of two parts: a Thesis and an Oral and Practical Examination. Candidates must submit the subject of their Thesis to the Dean for the approval of the Examiners on or before the 1st December, 1914, and the Theses must be delivered before the second part of the examination is held in the first week of June, 1915.

Guy's Hospital,
October 9th, 1914

War and Race-Regeneration.

A SERIES OF LECTURES
on the above subject will be held at the
KENSINGTON TOWN HALL,
at 8 p.m., under the auspices of the
National Council for the Promotion of Race-Regeneration.

C. W. Saleeby, Esq., M.D., F.R.S.Ed.—Friday, November 6th: Subject, "The Longest Price of War." Friday, November 13th: Subject, "The Nurture of the Race." Friday, November 20th: Subject, "War and Womanhood." Friday, November 27th: Subject, "Patriotism at Home."

Mrs. Mary Scharlieb, M.D.—Friday, December 4th: Subject, "The Duties of Women and Girls in Time of War."

Sir Victor Horsley, F.R.C.S.—Friday, December 11th: Subject, "State-Morality."

A few Reserved Seats at 1s. each. A Special Ticket for the Course of Six Lectures, 5s. Tickets to be obtained from the Secretary, The National Council of Public Morals, 42, Great Russell Street, W.C.

Admission Free.

Papers by Guy's Men.

E. W. Goodall, M.D.: Note on intubation instruments.—*Practitioner*, October, 1914.

R. G. Poole Lansdown, M.D., B.S., and another: The Etiology of Appendicitis, Gastric Ulcer, and Allied Conditions.—*British Journal of Surgery*, October, 1914.

T. B. Layton, M.S.: Twenty-seven cases of mouth-breathing studied in relation to the contraction of the Dental Arches.—*Dental Record*, October, 1914.

Alfred MacConkey, M.B., B.C. Cantab., D.P.H.: Tetanus: its prevention and treatment by means of antitetanic serum.—*British Medical Journal*, October 10th, 1914.

J. B. Parfitt, L.R.C.P., M.R.C.S., L.D.S. Eng.: The Cement Lute in Inlay Work.—*British Dental Journal*, October 15th, 1914.

E. W. Sheaf, M.C.: Treatment of Tetanus.—*British Medical Journal*, October 17th, 1914.

The British Pharmacopœia, 1914.

The fifth edition of the "British Pharmacopœia" was to have been published in August last, but owing to the war its issue was postponed. The reasons for this have not been made public, but apparently they no longer apply, and advance copies of the work are now on view at the Offices of the General Medical Council in London and also in Edinburgh and Dublin. The volume will actually be on sale and come into force on the last day of the present year.

Enough has already been written in the medical and pharmaceutical papers to enable one to judge of the character of the alterations that have been effected during a revision which has lasted some ten years or so. It has been the desire of the General Medical Council to obtain as much criticism of the details as possible before their inclusion in the official work, and to that end the various revisers have published reports from time to time bearing upon their researches. As a rule these have not received much attention, probably for the reason that until they are adopted one never knows if they are worth notice. A case in point has occurred in the writer's experience: a report upon some work was published in which the author had made rather a serious mistake. At the time there seemed no point in telling him so, but it is now found that the results from his work have been included in the new Pharmacopœia.

The preface of the present issue now enumerates the various steps that have been taken to deal with its revision by the General Medical Council. Among these have been the formation of Committees of Reference in botany, chemistry, and pharmacy, and it is obvious that to the last has fallen the lion's share in the revision; indeed, it is an open secret that they have acted, not so much as a committee of reference, but as a committee of revision.

Generally speaking, this edition is an advance on the previous one, the directions are more precise, and in some cases they occupy as little as half the space as formerly. There is also an improvement in the way the formulæ are set out, and it is certain that there is less risk of misreading and error. By adopting the centesimal system one can see at a glance the strength of preparations. One would have liked to have seen the formulæ for pills set out for one pill so that one may see how much active ingredient each contains. The same applies to suppositories where the quantities are given for one dozen. It would have avoided a serious possibility of error if the quantity for one suppository had been ordered.

Metric System.

An exceedingly important change has been made in introducing throughout the formulæ the metric system of weights and measures. The last edition was intended as a transitional stage from the English to the metric system, and each formula was expressed in the two systems side by side. This edition, therefore, carries the matter a step further and represents the culmination of this idea. As is stated in the preface, the medical man now employs the metric weights in the various laboratories in the course of his scientific training, and it is represented as being desirable that the system should be extended to medicine. It is now used for expressing the doses in the expectation that in the near future it will be adopted by British prescribers.

Having assumed that the medical student is so conversant with these weights, it seems hardly logical to state for his benefit the doses in the two systems. At the same time it is a surprising compliment to pharmacists to assume that their training has fitted them for the complete change and seems hardly justified in view of the experience of the "British Pharmaceutical Codex" which introduced the metric system in 1907, but was compelled to revert to the simultaneous use of both in its issue of 1911.

It will be very interesting to see how far medical practitioners, and especially physicians in hospitals who are engaged in teaching, and those responsible for the production of the various hospital pharmacopœias, will follow the lead of the General Medical Council and employ only the metric system. In order to be in a position to state the doses in the metric system, the term *mil*, which has been in the "Codex" for some time, has been adopted, instead of a millilitre, or as it is often called, a cubic centimetre. In order to have simple names for one-tenth and one-hundredth of this amount, the terms decimil and centimil, corresponding to deci- and centigrammes have been adopted, so that 0·5 c.c. will now become 5 decimils. In connection with prescribing, the new B.P. definitely recommends (on somewhat inadequate grounds) that the drachm and ounce signs should be discarded from prescriptions.

Doses.

With regard to doses, it is again stated, as in the preface of the last edition, that the doses are not authoritatively enjoined. The medical practitioner must act on his own responsibility as to the dose of a substance he may administer. An addition has now been made to this statement which appears to involve casting the responsibility of an overdose upon the pharmacist, for it is stated that where an unusually large dose appears to be prescribed, it is the duty of the pharmacist or dispenser to satisfy himself that the prescriber's intention has been correctly interpreted. Presumably the only guide a pharmacist can have as to whether a dose is excessive is that afforded by the Pharmacopœia. Taking into account the difficulty of obtaining such confirmation from the prescriber, it would appear more in accordance with general convenience if it had been enjoined that the

prescriber should confirm any dose exceeding the pharmacopœial limits by affixing his initials, as is the custom in most European countries.

There is very little alteration in the doses. Liquid paraffin has for the first time been assigned the maximum dose of four drachms. It would have been more in agreement with custom if the maximum dose had been stated to be one fluid ounce.

In a critical examination of the Pharmacopœia, one must judge it very largely from the standpoint of the intentions of its compilers. The preface states that one of its objects is to afford one uniform standard and guide whereby the nature and composition of substances to be used in medicine may be ascertained and determined. One expects the Pharmacopœia to give such details for the preparation of medicines contained in it so that any trained pharmacist should be able to prepare any preparation of the standard set forth. Nitroglycerin tablets form an instance where this has not been done. They are simply described as tablets of chocolate containing a definite amount of nitroglycerin. No directions are given as to their preparation, whether moulded or compressed, and no indication as to what "chocolate" is. Further, no process of estimation of the finished article is given. This is regrettable in view of the experiments recorded of the deficiency in strength of certain of the American variety.

One cannot accuse the new Pharmacopœia of showing undue regard to recent researches in pharmacy. What seems a flagrant example of this is the formula for preparing liquid extract of ergot. The old process has been retained in spite of the fact that it has been shown to be ineffectual in extracting more than a very small fraction of the ergotoxine present. Again, it has been recorded that when the ointment of cocaine is made according to the pharmacopœial directions it very soon loses strength, so that not only is there a fear of a serious deficiency in its therapeutic value, but there is also a danger that the unfortunate pharmacist, although he has conscientiously prepared it, may be prosecuted by failure on the part of the analyst to recognise the unavoidable depreciation in strength. A note for guidance would have saved much risk of trouble.

Articles Added.

It is not necessary to give a full list of the forty-three articles now added and thus made "official." They include the following important ones, against which are placed in brackets some of the trade names by which they have been known:—

Acetonum; Acidum Acetylsalicylicum (Aspirin, Xaxa); Adrenalinum; Barbitonum (Veronal); Benzaminæ Lactas (Beta-eucaine Lactate); Cantharidinum; Chloral Formamidum (Chloralamide); Cresol; Diamorphinæ Hydrochloridum (Heroin) "Codex" name, Diacetyl morphine Hydrochloride; Guaiacol; Guaiacol Carbonas; Hexamine (Urotropine) "Codex" name, Formamine; Liquor Cresol Saponatus (Lysol); Methyl Salicylas; Methylsulphonal (Trional); Phenolphthalein (Purgen); Theobrominæ et Sodii Salicylas (Diuretin).

This list is typical of the new official drugs; they are, generally speaking, synthetic organic substances or other definite compounds; new vegetable drugs are represented by senna fruit which is the only addition in this class. Cantharidin has been made official on the very sensible grounds that by its use it is easier to obtain uniformity in strength than when the beetle is employed.

Articles Deleted.

No less than 168 articles have been discarded, but a great proportion of these were only official in the Indian and Colonial Addendum, so that the rejections are less than it would seem at first. It may be stated here that Indian and Colonial drugs are now described in the body of the book and not in a separate volume, so that this can now claim to be a real Imperial work. Important deletions include the green extract of belladonna, the sulpho-carbolates of sodium and zinc, and all the concentrated solutions which became official in the last volume for use instead of concentrated infusions.

Articles not Included.

In the preface to the 1867 edition it was stated that the function of a pharmacopœia was not so much the selection as the definition of substances which the physician prescribes. The same idea is expressed in the next edition, where it was stated that the Council have endeavoured to include in it all such remedies as are in constant use.

In the edition under review it has evidently been the desire to include those which by inquiry have been shown to be frequently prescribed. It would, therefore, seem that if a substance is in frequent and steady demand by a large body of medical practitioners, a standard should be made for it by its inclusion in the Pharmacopœia.

On these grounds it is difficult to understand why such an article as extract of malt, which has been prescribed for the last thirty years or so, should not be included. Surely it is possible for medical opinion to decide which ingredients are the most valuable, when there would be no difficulty in framing appropriate processes for its preparation and determination. The same might be said of such largely prescribed articles as chemical food and cod-liver oil and paraffin emulsions. With regard to chemical food it may be that it is desirable that its use shall be given up in favour of a new iron preparation called Ferri Phosphas Saccharatus, but previous experience with Liquor Ethyl Nitritis shows that it is by no means easy to inaugurate the use of a preparation simply by including it in the Pharmacopœia. On the other hand, it is difficult to justify the inclusion of such infrequently prescribed preparations as Oleum Phosphoratum and Mistura Ammoniaci.

Finally, one must express sympathy with all future apprentices in pharmacy for an alteration in composition of the compound tincture of cardamoms. The ripe fruit of *Vitis Vinifera* has now been replaced by glycerin.

H. FINNEMORE.

Injuries of the Semilunar Cartilages.

CLINICAL LECTURE BY C. H. FAGGE, M.S., F.R.C.S.

Gentlemen,—The subject of injuries to the semilunar cartilages is, in England, an old one. Every description of this lesion in the text-books begins with the statement that more than a hundred years ago, Hey, put together the clinical picture of a traumatic lesion of the knee, which he called internal derangement of the knee-joint. There is no doubt that, in early cases, traumatic internal derangement sufficiently defines the mental attitude of the surgeon; the term is now gradually dropping out but seems to have something to commend it, because in the early stages diagnosis is almost impossible as is shown by the statement of that well-known orthopædic surgeon, Robert Jones, of Liverpool, who wrote that he never opened a knee-joint with any sense of security or with a certainty that he would find the lesion which he expected; also that he was never disappointed to find that the condition which he had diagnosed before operation was not present. When a surgeon with the reputation and clinical experience of Robert Jones makes such a statement, it must have considerable weight, for in the same paper he said he was writing an account of his experience of five hundred operations on the knee.

About a year ago I was interested in the question of injuries of the knee, and read most of the literature which was available in London on the subject of such injuries. It struck me as very curious—and perhaps fortunate for me—that practically all the literature on the question was in English. A well-known French text-book dismisses the subject in less than a page, describing it as a injury of Anglo-Saxons given to violent exercises, particularly football. Many of you know the very comprehensive literature which, from time to time, is put out by the Mayo clinic. Four large volumes have been issued since the year 1909, but there is no single word upon any injury to the knee-joint in these, and the curious exception to the fact that this is an injury of the knee-joints of those given to violent games is, that it does not seem to take place with any frequency in America.

During the week of the Clinical Congress last July, I happened, partly on purpose, but more by chance, to operate on two supposed lesions of the semilunar cartilages. And the reason I did it was, because in my short visit to the States I never saw an operation on the semilunar cartilages, or upon any traumatic condition of the knee joint; therefore, I thought it might be of interest to members of the Congress. One surgeon from New York, whom it is my pleasure to count as a friend, said that in his clinical experience these operations were very infrequent.

There was practically no German literature on the question, but one of the best known text-books in German (Koenig) says that their knowledge of the condition was largely due to Mayo Robson. And it is one of many subjects which Mayo Robson's vast clinical experience and considerable operative technique did much to illuminate; he labelled the condition from what he saw in the north as "miner's knee." It was not until about the year 1900 that the knee-joint was explored with any sense of security, and about that time Sir Arbuthnot Lane wrote a paper on injured semilunars, and suggested that they offered a focus for the onset of knee-joint tuberculosis, a view which has recently been supported by Robert Jones. In the proceedings of the Royal Society of Medicine for 1912, there are two interesting papers on injuries to the semilunars; one came from Mr. Martin, of Newcastle, where they know more about injuries to the knee than in any other town in England. The report of the Royal Victoria Infirmary, Newcastle-on-Tyne, for the year 1911, contains details of 156 cases which were operated upon for injuries of the semilunar cartilages. It is interesting that only two of them were women; in 151 instances the internal semilunar was injured, and there were six torn external semilunars. In one case, both the internal and external semilunars were operated upon.

Martin's paper above mentioned deals with his own experience of 449 cases; of these, 62 per cent. were miners, and 18 per cent. of them were due to football accidents. And then comes the most important fact, to my mind, connected with injuries of semilunars, which I have learned during the last two or three years, namely, that in 95·5 per cent. the cartilage was torn. To talk of a displaced or detached semilunar cartilage is, in itself, a misnomer, and it is a much worse mistake to say so than appears at first sight; because if the substance of the cartilage is torn, and in every case a portion of cartilage remains in contact with the peripheral capsule, it is pretty clear that any effort—and the efforts were very frequent in the early surgery of the semilunar cartilage—any effort to suture it back in position must, more or less,

necessarily fail, because union of cartilaginous tissue after tearing is likely to be bad; cartilage is a tissue which does not heal well. The way in which we talk about detached semilunar cartilages is only one instance of a very common feature of surgery. We are inclined to operate for a condition, to say what we think there is to remove, and to say what we expect to find wrong. We do not often—and the older we get the less inclined we are to do this—modify our preconceived opinion by the conditions we find. And one of the most important mechanical factors on which these mistakes depend is, that so many people think they can find out exactly what is wrong with the knee-joint, however minute the incision. If you see surgeons like Jones, Martin, and Rutherford Morison operate upon a semilunar cartilage, you will appreciate that they only do so through a very free incision.

The discussion at the Royal Society of Medicine was interesting because Mr. Walton, of the London Hospital, put forth the idea that the commonly accepted view as to the way in which the semilunar cartilage was injured, was wrong. He argued that the most important feature in an injury of the semilunar cartilage—and when I say semilunar cartilage I nearly always mean the internal one—was rotation. And being interested at the time mainly in mechanical studies, he perhaps pushed his anatomical inferences a little too far. He argued that rotation in the knee joint commonly takes place only at the end of extension, or at the beginning of flexion, just as you may have read in Cunningham's Anatomy, where a very good account of the movements of the knee is given. On this premise Walton argued that injuries to the semilunar cartilage only take place with the knee hyper-extended.

It is rather sad that we are always inclined to think that because a young man says a thing which is not in accordance with our pre-conceived ideas, that it is necessarily wrong. I do not say that Mr. Walton is right in this matter, but I think his critics might have realized that their own pre-conceived conception as to the method by which these injuries were produced was not logical or conclusive in all its aspects, and that there might be a good deal of truth in what Mr. Walton said.

There is, however, no getting away from the fact which Mr. Martin, of Newcastle, well brought out, that the injury as commonly seen in the North occurs with the knee flexed, because in that part of the world the coal seams are so low that all the men work practically in the sitting posture. I gathered from an old Newcastle resident, who had seen a good deal of surgery there as Mr. Morison's assistant, that the miners work practically sitting on the right heel, and that in most cases a fall of coal actually pushes the knee inwards.

There is no doubt that, as we see it down South, the injury to the semilunar is due to indirect violence occurring with the knee semi-flexed, abducted, and generally with the femur rotated inwards. But I think Mr. Walton has done the subject a service by pointing out that at the time the person is injuring his knee in this way, he is making an effort to extend it. Imagine a tennis player or football player momentarily poised on one leg, with the knee slightly flexed and abducted, when someone tries to collar him, or hits the tennis ball on the other side of him, and in either case he tries to turn, forcibly rotating his knee. But while he is trying to turn, it is clear he must be making an effort to extend the joint.

When the knee is flexed, the capacity of the joint is greatest; thus, all inflamed knee-joints adopt the position of semi-flexion, and when the capacity of the joint is greatest, there is the greater need for the packing structures to fill up the different spaces, and the semilunars as one of these packing materials are drawn towards the centre of the joint. As the knee is extended, these cartilages, particularly the internal, are drawn out towards the periphery by the stretching of the lateral ligaments. Let us suppose, then, that in the semi-flexed position the central concave border of one cartilage is by chance nipped between the two bones, and the sudden effort at extension drags the lateral ligament and the circumferential convex margin of the semilunar towards the surface; in the case of the internal it will be inwards, and in the case of the external it will be outwards. And so it is split, as you would tear a piece of linen, by two forces acting in opposed directions. It is important to realise that in nearly every case there is a tear. I have no doubt that rotation is a very important feature in its production, and probably one of the factors which influence the percentage proportion of the injuries to the internal, as compared with the external semilunar, is the fact that rotation mostly takes place on the inner side of the knee joint. You may remember the account of the internal condyle of the femur screwing its way home, as described in Cunningham's Anatomy, which will help to account for the figures from Newcastle, 148 internal semilunars injured as against 6 external, which shows the great proportion of internal as compared with external semilunar injuries.

The most important anatomical fact, however, which accounts for this disproportion is, no doubt, the firm attachment, circumferentially, of the internal semilunar to the internal lateral ligament. This is not found on the outer side, for the external lateral ligament is kept away from the external semilunar by the popliteus tendon and the synovial sac which intervenes. You can see, in most anatomical preparations of the knee-joint, that a shrinking inwards towards the centre of the joint does take place in flexion, and that the cartilages tend to be expressed out of the joint cavity in extension. You can almost demonstrate that for yourselves by flexing and extending your own knee.

There seems to be no real reason why the right should be more often affected than the left, but so it is. Leaving now anatomical considerations, of which I have only touched the fringe—because movement of the knee-joint is a very interesting question—we come to a consideration of the symptoms which are produced by injury of the semilunars. Rutherford Morison (*Clinical Journal*, April 9th, 1913), gave a very clear symptom-complex which he regarded as typical of semilunar injuries, as follows: (1) a really severe injury which is associated with considerable pain followed by effusion into the joint, and which lays the individual up for a period, perhaps for a fortnight in bed, and will incapacitate him for several weeks from following his ordinary occupation. (2) This injury, so severe as to be well remembered, is followed by a period of complete freedom, only to be again interrupted by troubles in the knee, which are often due to slight causes, are of short duration, and sometimes associated with effusion, and which come on quite unexpectedly.

I happened, by chance, to operate on a girl this morning who was regarded by her doctor as having an injury to the internal semilunar. She is, in some respects, an exception to what I have been telling you, because she is not only a girl, but a French girl, but her history is in most respects typical of what Mr. Morison says, and will serve to illustrate his points. I saw her a fortnight ago, when she told me that in the early spring of 1911 she was playing tennis in England; when jumping over the tennis net she caught her foot in the top of the net, which accident, in spite of almost immediate treatment, was followed by effusion, and she thinks she was in bed three weeks, and was not allowed to do anything for five weeks. In the next year she slipped on the stairs and hurt her knee again. A third attack occurred in 1913, and in May of this year an interesting thing happened, because, owing to some trivial cause which I have forgotten, her knee became locked. A fortnight ago she was kneeling in church, and when trying to rise from that posture her knee locked again. She sent for the doctor, who unlocked it. When I saw her next day the knee-joint was full of fluid. Her mother said it was certain that after any excessive exercise this knee-joint was larger than its fellow. The knee-joint was opened, the internal semilunar found torn anteriorly, and the anterior part removed.

Rutherford Morison, in his account of these cases, does not lay stress on one point which is prominently given in some books as pathognomonic of semilunar injury—that of locking; and if you look at the question logically, one would expect Mr. Morison to be right. Any loose body in the knee-joint which happens to come between the opposed articular cartilaginous surfaces may produce locking, just as by putting a stone in one of the hinges of a swing-door you will prevent it shutting, or by putting a stone on the other side you will prevent it being opened. Locking means a limitation of movement in one direction. It is not unusual to get a history of locking with semilunar injuries, but locking in both directions is very rare; thus, this girl, who was a good example of locking towards extension, could allow her knee to be freely flexed beyond the right angle, but it could not be extended to the full extent.

The piece which is torn projects, and gets in the way, between the cartilaginous surfaces, and generally rather to the front of the joint, and so prevents extension.

There is only one variety of injury to semilunar cartilages which apparently does not give a typical history, and that is the variety which Morison called the "bucket-handle" fracture. Here there is a longitudinal tear right along the semilunar, and the free piece remains attached in front and behind, but is not connected with the rest of the cartilage at its peripheral margin. Early in the summer I was operating upon another girl sent in as suffering from a torn semilunar. Do not think from this that my experience of this injury in girls is a large one, I have only operated upon three girls for it, and I own that even this number in my small total experience of this injury is exceptional and shows that one cannot found any statistical evidence on a small number of cases. The history of this girl did not quite conform to what I have told you of semilunar injuries. It was that the condition was of a year's duration, and the attacks had

been so frequent and the disability so continuous as to interfere with her occupation as a servant. I did not feel definite enough about the condition to justify me in refusing to operate, but, candidly, I was quite sceptical as to her having an injury of the internal semilunar; I thought she had one of the other conditions which may easily be confused with injury to the semilunar, and said so at the time. On opening the joint I found what I took to be a normal semilunar, but between the condyles of the femur there was a strip of cartilage passing from back to front.

This was displaced outwards into the intercondylar notch, and, in fact, looked like the handle of a bucket. I have had experience of only two of those cases, and therefore know very little about the condition from personal experience; but Rutherford Morison rather makes a point that in cases in which this type of lesion exists the intermittent, interrupted history characteristic of the common type is not obtainable.

With regard to the diagnosis of the condition, there is even now, as you will have gathered, some considerable doubt. In his more recent papers Mr. Robert Jones does not dilate so much on the difficulty of diagnosis, or on the uncertainty with which he now opens a knee joint, but I do feel very strongly that one should realise that there are other conditions which are easily mistaken for injury of the semilunar.

The most common of these is a form of chronic synovitis, in which all the synovial fringes—the ligamentum mucosa, for instance—are hypertrophied and thickened. One of these fringes will often produce disability by being picked up between the two articular surfaces, and will give a history which is easily confused with that of a case of injured semilunar. But if you dissect the history carefully you will usually find that there has not been one severe well-remembered injury which has been followed by a succession of slight attacks. This condition of villous synovitis is often part of a general traumatic arthritis of the knee, which is particularly common in middle-aged men, particularly working men at this period of life who have been out of work for some time and then go to a hard job for which they are not physically fit. They are very apt to get a progressive incapacitating arthritis of the knee, which, however, they are very apt to attribute to injury, and sometimes the condition is mistaken for an injured semilunar. In progressive traumatic arthritis of the knee operation does harm, for I know of two or three cases that have been operated upon, and in which the disability has been increased by the operation. If a man over 30 comes under my care with a knee injury, I am doubtful about it being a torn semilunar. Of the cases on which Mr. Walton's paper was formed, 53 were below 30, and 20 were over 30 years of age. I should not have thought there was anything like this approach to equality of numbers, but rather that the proportion was 10 under to 1 over thirty.

Less common traumatisms of the knee-joint are pieces of cartilage knocked of, forming those fugitive loose bodies (joint-mice) in the knee which are so difficult to find when the knee-joint is opened. There is also the organisation of a synovial exudation into the knee, giving rise to those loose bodies known as "melon-seed bodies." Even isolated synovial fringes which have hypertrophied may give rise to difficulty in diagnosis, but are not important because, in the majority of instances, the treatment is the same. I remember a case illustrating this, that of a sailor, in which I opened the knee-joint with the idea that he had an injured internal semilunar. I found one of the infra-patellar pads of fat, which was very thick; it was, in fact, a hypertrophied ligamentum mucosum torn away from its attachment to the intercondylar notch, and, the cartilages both being perfectly sound, this was removed. The man had no subsequent attacks during several months in which he was under observation.

Sometime ago I was very much puzzled by a little girl, æt. 10, whose knee made an extraordinary noise when she bent it. I felt certain there was a loose body in the joint, which, in certain positions, got between the articular surfaces, and was released with a snapping noise. There is a condition of the hip which the French call "hanche à ressort," and so condition of the knee may be called "genou à ressort." I find, as is nearly always the case, that someone else has described the same thing, and put it down to the right cause. In my case the correct cause was only made known to me by Mr. Townrow, who was then Surgical Registrar. When he saw the patient in the ward he said he thought he knew what the trouble was, as he had seen two or three like it, and in each case the external semilunar was loose.

I found later that Mr. Robert Jones (*Annals of Surgery, 1909*) describes exactly the same condition as "the snapping or clicking knee, a condition very puzzling, . . . is a loud click on acute flexion and sometimes on complete extension." Jones goes on: "This is described as trig-

ger knee because of its characteristic snap. . . . The cause of the difficulty is generally ascribed to disturbance of movement of the external semilunar." In my little girl it was only heard when the knee was nearly approaching full flexion; then the click was heard, and the whole knee-joint seemed to stagger; similarly, soon after extension began, the sound recurred and then the leg came forwards noiselessly and freely.

The external semilunar was found to be at fault, for the posterior part, where it is normally free, was mobile and thickened. When the anterior part of the cartilage had been cut through, the free thickened part could be pulled forward so as to become impacted between the articular surfaces, and in both extension and flexion the clicking noise could be caused by its release. This was removed, and the noise did not recur, either on the table or when she was sent out of the hospital.

Treatment.—During the initial attack of injury to the cartilage, its presence can be only suspected. There is a complete agreement among authorities that operation is not justified in a first attack: grave suspicion of semilunar injury may be aroused, but this does not justify operation. I have many times seen men whom I have suspected or provisionally diagnosed as torn semilunars, but who on later visits have shown a normal knee and a freedom from attacks for months or years. During the acute attack immediate treatment is very important. Much pain is avoided by the early application of firm elastic pressure over the knee by a large covering of cotton wool and a firm bandage; a rubber bandage if obtainable is best, and the joint is maintained as nearly extended as comfortable without a splint. The firm bandage may cause some swelling of the foot, but that does not matter if it causes no pain.

With regard to the method by which, if the knee is locked, you should reduce the locking, the great thing to do is to very firmly and fully flex, and then extend, rotating inwards a little. Most of the loose bodies which are locked between the joint surfaces can be so released.

I have very little to say about the non-operative treatment. Instruments have been designed, of which the best is that known as Hawksley's splint, which is recommended in most text-books. These, no doubt, merely reflect the opinion of some years ago, and nobody would now advise the instrumental treatment of a torn semilunar cartilage, excepting under unusual circumstances, as in a patient who was old or debarred from any active exercise.

With regard to the operative treatment, there seems to be an equal division between those surgeons who make a transverse incision extending from the inner border of the ligamentum patellæ to the internal lateral ligament, and those who make a vertical incision. In my thinking it does not matter which is employed so long as the incision is free, allowing the interior of the knee-joint to be thoroughly examined: this is best done with the joint in the fully flexed position. A free vertical incision is my practice, extending from the upper limit of the tibia on the inner side of the patella well into the aponeurotic expansion of the vastus internus. By that means the interior can be seen, and the position of the cartilage can be judged as the joint is flexed and extended. Many surgeons advise the application of a tourniquet to the thigh before operation. It always seems to me that if you suspect bleeding during an operation, it is best, as it is surgically sound, to see the bleeding spot and deal with it. I would rather see where the bleeding is, and deal with it at the time, than that there should be any risk of bleeding taking place into the joint.

Yet in spite of care in this respect the only complication to be feared is distension of the joint with blood; only a year or two ago a man in Lazarus was operated upon by me for an injured semilunar cartilage, and this was followed by an effusion of blood into his knee. His temperature rose on the second and third day with pain and tenderness, and this was so alarming that I opened the knee-joint again. Much blood clot, which fortunately proved sterile, was turned out and the joint was sewn up again. In my experience, such post-operative hæmorrhage is the only complication in these cases to be found. It may usually be avoided by applying a large pad as dressing, and a plentiful layer of cotton wool tightly secured by a Domette bandage. The vessel which is likely to bleed is one taking part in the anastomosis between the inferior external and the superior internal articular arteries behind the ligamentum patellæ; as the incision comes down on the inner side of the patella, this vessel is met with in the extra-synovial fat, not in the substance of the synovial membrane. It is common to find a fairly large vessel in this position, which is usually divided, and if after the operation is completed by the removal of the affected piece of cartilage, the capsule is sewn up in a separate layer from that suturing the synovial membrane, the vessel can usually be controlled by the second suture, and no ligature is necessary.

It is of great importance that one should never ignore the risk of sepsis in a joint, but at the present day I do not think there is any probability of infection of a knee-joint under ordinary conditions. This question, which many text-books discuss at length, is one the importance of which has largely died out at the present time. As far as I know, every case of this lesion on which I have operated has been, during the time it has been watched, free from recurrenee of attacks, and movements and strength of the joint has returned to the normal. Mr. D'Arcy Power has reported the after-histories of 89 cases at St. Bartholomew's Hospital, and found that in 73 there was no return of the symptoms.

One of the cases in whom, on July 31st, I opened a knee-joint before the American Congress illustrates a point of interest, for everybody was certain that the man had a torn semilunar cartilage on the inner side of his knee. The internal semilunar was normal, and there was no great object in taking a piece out of it. But the case well illustrates the importance of a free incision, for through the large incision on the inner side could be seen a thick flap torn from the external semilunar, so a second incision on the outer side of the patella was made and the affected part of the external semilunar removed. This patient came up to Out-Patients recently, forty days from the time he had been operated upon. Two long scars were to be seen, one on each side of the patella, and though the synovial membrane and capsule were only controlled by catgut sutures at the operation, he had a good sound firm knee-joint, and was walking about on it just as well as if he had had only a small incision in one place.

There is no evidence that operation will be followed either by weakness or by stiffness of the joint. The only disadvantages of operation I have seen have been in the knee-joints of elderly men in whom the diagnosis has been suspected rather than made definitely, and who have been unsuitable for operation, and in whom the condition of degenerative arthritis of the knee has been accentuated by the operation.

Gazette Special Pathologist.

S.C.C, Martock.—It is impossible to give a definite report upon this specimen, as it is too small and does not include any normal surrounding tissues. It shows enlargement of the skin papillæ with great œdema and inflammatory changes The epidermis is thickened between and upon the papillæ, but there is nothing to be seen which is definitely a malignant growth.

PATHOLOGIST.

Appointments.

Medical School Appointments.

October–December, 1914.

Clinical Assistants.—Messrs. H. L. P. Peregrine, G. W. King, S. Wilson.

Clinical Assistants in Medical Wards (with charge of Assistant Physicians' Beds and Out-Patients).—R. Sells (Dr. Hale White); R. Curle (Dr. Shaw); R. A. Holmes (Dr. Fawcett); E. J. Cooke (Dr. Beddard).

Clinical Assistants in Surgical Wards.—G. A. Pratt (Mr. Dunn); A. J. Drew (Sir A. Fripp); F. H. Dodd (Mr. Steward).

Dressers and Clerks in Special Departments:—

Throat and Ear, Genito-Urinary, and Children.—Messrs. K. N. Purkis, V. R. Hirsch, E. Biddle.

Throat and Ear, Skin, and Orthopædics.—Messrs. L. H. B. Evans, G. L. Attwater, F. A. Knott, D. H. A. Galbraith.

Eye and Nervous System.—Messrs. K. Westman, V. E. Lloyd (Mr. Eason); J. F. H. Stallman, D. O. Richards (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. C. W. W. Baxter, B. F. Sampson, J. G. Stevens, G. B. Tarring, G. S. B. Long (Mr. Bellingham Smith); J. E. Clark, C. H. Edwards, M. J. T. Wallis, J. F. Mackenzie, A. L. Punch, G. D. Gripper (Mr. Chapple).

Surgeons' Dressers.—Messrs. A. G. East, G. Noott (Sir W. A. Lane); A. W. Cocking, H. Lamb, W. D. Newland (Mr. Dunn); A. D. Marston, D. M. P. Whitcombe, J. B. Fairclough (Sir A. Fripp); A. Traill, E. S. Bowes, E. M. Litchfield (Mr. Steward).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. W. H. A. Pratt (Dr. Hale White); N. H. Maelzer, H. M. Gray (Dr. Shaw); I. R. Brogden (Dr. Fawcett); P. G. McEvedy (Dr. Beddard).

Medical Ward Clerks.—M. B. M. Tweed, N. A. H. Barlow, E. S. Phillips, M. C. Joynt, P. D. Chapman, L. S. Gathergood, T. E. Micklem, H. I. Sterne Howitt, I. Tewfik, H. W. Eddison, J. S. Ellis, B. E. Jerwood, F. N. Sidebotham, A. M. Ahmad, G. E. Kidman. K. R. Traill.

Assistant Surgeons' Dressers.—Messrs. E. N. Glover, K. N. Woodruff (Mr. Fagge); H. J. Bensted, H. S. Wacher (Mr. Rowlands); G. B. Dowling, G. E. L. Simons (Mr. Turner); R. L. Portway, W. J. Vance (Mr. Hughes); W. B. Buer, D. V. Halstead (Mr. Davies-Colley).

Surgical Ward Clerks.—Messrs. G. W. Heckels, H. E. Bamber, H. S. Vertue, W. Burridge, R. S. Millar, N. L. Watt, C. L. Odam, J. W. H. Grice, J. M. H. Campbell, T. L. Heath, J. T. T. Forbes, A. W. A. Davies.

Student Assistant in the Bacteriological Department.—Mr. W. M. Lansdale.

Student Demonstrator of Microscopical Pathology.—Mr. R. Quesada.

Pathological Assistant to the Demonstrators of Morbid Anatomy.—Mr. D. H. A. Galbraith.

Naval.

G. W. C. Hollist, Temporary Surgeon to *Excellent*, additional for the *Sirius*, on commissioning, undated.

Surgeon R. A. Rankine to the *Cyclops*, additional to date October 6th.

Surgeon K. H. Hole to the *Victory*, additional to date October 10th.

Fleet-Surgeon P. M. May to the *Victory*, additional to date October 10th.

C. Warner, Temporary Surgeon to the *Devonshire*.

Guy Neely, Sub-Lieutenant R.N. Volunteer Reserve.

R. W. White, Dental Surgeon with the Fleet.

To be Surgeon Probationers for temporary service: A. F. G. Guinness, L. S. Fry.

Civil.

R. G. Poole Lansdown, M.D., B.S., has been elected President of the Bath and Bristol Branch, B.M.A.

F. Morres has been appointed 2nd Assistant Medical Officer, L.C.C. Asylum, Cane Hill, Coulsdon, Surrey, dated September, 1914.

Royal Naval Medical Corps.

To be Lieutenants (Special Reserve): J. S. Cocks, E. C. W. Starling, J. York-Moore, C. H. G. Penny, J. H. Owen, H. G. Crawford, W. L. E. Reynolds. G. J. Watkin.

R. G. P. Lansdown, M.D., B.S., to be Major R.A.M.C.T. 2nd Southern Hospital.

W. T. Chaning-Pearce, Temp. Lieut., 66th Brigade, Seaford Camp, Sussex.

A. T. Falwasser, to be Capt., 1st Home Counties Field Ambulance.

C. F. L. Ruck, to be Lieut. R.A.M.C.T.

Attached to other Units.

Lieut. L. D. B. Cogan to be Captain.

C. A. Ensor to be Captain.

J. J. Conybeare, to be Captain 4th Oxford and Bucks Light Infantry, Writtle, Chelmsford.

R. G. Farrington, Sergt., City of London Roughriders.

T. E. Henderson, Public Schools Battalion.

J. H. Hinton, Capt. 1st North Midland Brigade, R.F.A.

E. D. R. Jacob, Capt. R. G. Artillery (Freshwater).

R. Manton King, Sergt. 4th Royal Sussex Regiment.

H. B. Neely, Second Lieut. 3rd Suffolk Regiment.

C. J. Lamb, Dental Surgeon attached to the Fortress Hospital, Devonport.

Dr. E. M. Mahon has joined the French Red Cross and has left for Paris, as Surgeon.

P. R. Chevreau has joined the British Red Cross and has also left for Paris, as Surgeon.

Mentioned in Dispatches.

The undermentioned gentlemen have been mentioned in Sir John French's dispatches for distinguished services:—

Lieut. H. L. Hopkins, R.A.M.C.

Capt. Malcolm Leckie, R.A.M.C.

Capt. A. C. Osburn, R.A.M.C.

With the Belgian Wounded at Folkestone.

"Qualified men and dressers are urgently wanted to go down by special train to Folkestone this evening to deal with four thousand Belgian wounded who have arrived from Ostend."

This message reached us at 8.45 p.m. on the evening of October 18th, and after a hurried call for volunteers a party of twelve, including Residents and Dressers left at 9.20 p.m. for Charing Cross, where in company with units from other hospitals we reported ourselves to the Colonel-in-Charge, and were told off to a waiting-room before entraining.

We were an earnest if somewhat motley band as we sat in groups discussing the chances of work which lay ahead of us. Here were uniformed members of the Officers' Training Corps armed with splints; there were men in mufti whose travel-stained Red Cross brassards showed that they were but lately from the seat of war; here, again, were others who hoped to serve there soon. And it was with a tense thrill of expectancy that we moved off through the station between lines of eager and silent spectators to the well-equipped hospital train which had been placed at our disposal by the military authorities.

We made the journey to Folkestone in an hour and a half and after crowding out on to a darkened platform started without any definite orders as midnight struck for an unknown destination. The town itself was in absolute darkness, and the muffled tread of our feet on the asphalt roads, broken only by the hurried consultations of our guide when he lost his way at the turnings, lent an eerie aspect to the night, and it was not surprising that half the party lost their way and would doubtless have been drowned in the sea had they not fortunately met the local mayor walking home to bed. Eventually as we sniffed for the first time the fresh sea air we came upon the Hotel Metropole, a blaze of light and full of excitement. The visitors had received summary orders at 9.30 p.m. to quit, and Belgian wounded had already begun to arrive in motors from the harbour; so we quickened our step and braced ourselves for the work before us.

As we entered the throng in the vestibule a varied sight met our gaze of hotel staff, visitors, nurses, and wounded men; here a Belgian soldier limping about, his rifle and bayonet still tightly grasped; there another in cavalry uniform whose face betokened the agony of a splintered arm; there, again, a third, his head a mass of bandages still clinging to his battered knapsack; while a little apart a group of travel-stained women with Red Cross badges chatting to a Belgian officer, or pressing nourishment upon the new arrivals. Our first impression, however, was that the wounded seemed comparatively fit, and needed little

or no assistance, but a nurse murmured of a case of peritonitis, and our spirits rose.

The hotel staff was valiantly equal to the occasion, and after a hearty meal we assembled in the hall to receive our orders, only to realise for the first time what organisation or lack of organisation really means. The Colonel asked for the dressings which had been brought down, but the supply proved so small that a raid on the local chemist was suggested, while his further appeal, "Has anyone brought down any antiseptics at all with him?" was answered by a man who had a small bottle of iodine, and who thenceforth became a man to know, and finally a subaltern appeared on the stairs above to say that a few of the wounded certainly wanted dressings, though, as we found later, the majority had been attended to in Ostend.

At this point the superb organisation broke down completely, and amid a confused babble of voices, above which rose mystic cries of "Pass the word; pass the word there," or "Hold on there, you," or "Ouvrez, ouvrez la porte" in the best Anglicised French, the contingent scattered to make beds and do some dressings. And so chaos followed on chaos, and it was heart-rending to find worn-out soldiers peacefully asleep on the floor who had to be awakened and put to bed in the orthodox fashion, but they were cheerful with it all and delighted to be among friends.

I then had a chance of examining some of the wounded, and one of the most interesting cases that I saw was that of a man with a bruised thumb who had sustained his injury, appropriately enough, at Knocke, while another had a healed bayonet wound in his hand which he had received at Louvain six weeks ago. This occupied us until 2.30 a.m., when we began to feel the need of fresh air, so we took a walk over the Leas and down to the harbour where another boat of wounded lay, returning later to the Metropole to find that order reigned at last over chaos, and that the wounded slept.

But we sat listening to stirring tales from the seat of war far on towards dawn, to tales by a Russian surgeon from Antwerp of miraculous escapes from bullet wounds, of children murdered by bayonet thrusts, of German treachery with the Red Cross, and of marvellous recoveries from what seemed certainly mortal wounds; to tales from our own friends of everyday deeds of valour among the wounded or panic from Zeppelins overhead, until finally, the authorities decided to land the rest of the wounded, and we were marched down to assist the disembarkation by our distinguished presence.

Then, as dawn broke slowly on the dull grey cliffs of England, another stream of wounded passed painfully down the narrow gangway, and, assisted by eager hands, entered the waiting trains: infantrymen wounded in the foot and leg, cavalrymen with injured arms, here and there a member of the civic guard wearing his quaint felt shako, all carrying the stamp of hardships willingly and cheerfully borne to save their homes. It was a sight not easily to be forgotten as this remnant of a gallant army passed in silence to the train.

This work accomplished, we took our mute farewell of the harbour and of our officers now fast asleep on the Leas above, and returned to Guy's, not sadder, but much wiser men. "C'est magnifique, mais ce n'est pas la guerre." E. S. T.

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of the Published Writings of the late Sir Henry Greenway Howse, D.Sc.Vict., M.S., F.R.C.S.

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Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

A Short Handbook of Cosmetics. By Dr. Max Joseph. (William Heinemann.) Price 2s. 6d.

Few English practitioners are likely to have the time or inclination to digest the author's larger "Handbuch der Kosmetik," or the still more elaborate "Kosmetik für Aerzte" of Paschkis, so that the second and revised edition of Dr. Joseph's small book should prove of value. For even among professed dermatologists the subject of cosmetic treatment is strangely neglected in this country.

This may be the fault of our womenfolk, since the majority of them seem to possess neither the instinct nor the desire to remedy the defects of figure and complexion with which Nature or their own indifference may have endowed them.

There are indications, however, that the old order is changing; the war is making London, at any rate, more and more the willing slave of Paris fashions and the home of Parisiennes, and just as there is a friendly rivalry between our soldiers and the French at the front, so surely will English women not allow *nos amies* from the other side of the channel to have things all their own way.

It therefore behoves our medical men to take the treatment of such things as "bad complexions" and "falling hair" out of the hands of unqualified and, in many cases, unscrupulous and ignorant quacks. For it is obvious that, as every form of dyspepsia is not cured by one and the same mixture, so every form of bad complexion or baldness will not yield to one particular ointment or hair lotion. This fact once and for all condemns all "secret remedies," and treatments by post.

To achieve success in the treatment of these cases, it is essential to have a clear idea of the underlying causes, and unless the practitioner has some knowledge of the etiology of the commoner skin diseases—such as the seborrhœic complaints, acne, etc.—he had better, though he be armed with a book on cosmetics, leave such matters to the specialist. The time and effort required, however, to acquire such knowledge is so little, whereas the profit accruing therefrom will prove so great, that anyone who takes the trouble to learn will be amply repaid; and the great advantage of such a book as the one under discussion over the average text book of dermatology is that the preparations given are in most cases sufficiently subtly compounded as to be suitable for better class practice. The art of perfumery is of no mean importance when one is dealing with a sensitive patient, and it is in such apparent trivialities as these that the French doctors and chemists score so heavily over our own.

The chief value of Dr. Joseph's book lies in its wealth of prescriptions; the subject matter is, perhaps, almost too brief, and in this respect Taalfeld's "Lectures on Cosmetic Treatment" (translated by Dr. Halls Dally, and also published by Heinemann) is to be preferred. Although the fact is indicated in his translator's appendix, Dr. Joseph omits to mention that the use of resorcin, tannobromine, thiol, etc., for the hair by blondes is liable to produce unpleasant results, and should be avoided. Euresol, the mono-acetate of resorcin, is a good but somewhat expensive substitute.

With regard to the translator's remarks on alopecia areata in the appendix, we are of the opinion that, except in certain obvious neurotrophic cases, *i.e.*, when the bald area corresponds exactly to the distribution of a nerve, the disease is certainly parasitic, and the best results are obtained by the use of the X-rays, or by painting pure phenol or lysol on and just round the patches. The latter method often produces a rapid and satisfactory cure.

We hope that the indifference and contempt which has hitherto characterised the attitude of the English medical profession towards the art of cosmetics will disappear with the advent of French ideas in this country. Let us say with the prince of our essayists: "Artifice, whom we drove forth, has returned among us. . . . . Artifice, sweetest exile, is come into her kingdom. Let us dance her a welcome."

Pass List.

Conjoint Examination.

First Examination.

†A. R. Neckles. *Sidney Wolff.
‡B. M. Tonkin,

† Chemistry. * Physics. ‡ Elementary Biology.

Practical Pharmacy.

C. C. G. Gibson. R. Quesada.
L. A. J. Graham. W. L. E. Reynolds.
A. L. S. Payne.

Second Examination.—Anatomy and Physiology.

H. F. G. Berncastle. J. T. T. Forbes.
A. W. A. Davies. R. S. Millar.
T. L. Heath.

Society of Apothecaries.

Anatomy.

F. J. Harrington.

Royal College of Surgeons, L.D.S.

PRELIMINARY SCIENCE EXAMINATION.

Part I.—Chemistry. Part II.—Physics.

A. S. Blacklaws. D. E. Robinson.
*John Herbert. *E. F. Shaw.
F. G. Knowler. W. A. Woodward.

*Chemistry only.

Change of Address.

Dr. J. M. Brydone, from 16, South Audley Street, to 18, Charles Street, Mayfair. (Telephone, 703 Mayfair, *same*.)

C. W. Morris, from 47, Upper Brook Street, to 88, Park Street, W.

F. W. Paul, from "Glendornie," Gordon Road, Camberley, to M.F.A., "*Rohilla*," Hospital Ship No. 2, c/o G.P.O.

Births.

HOUSDEN.—On Thursday, September 17th, at Hatfield, Guildford, the wife of Charles H. Housden, L.D.S. Eng., of a son.

HUGHES.—On September 18th, at 37, Queen Anne Street, Cavendish Square, W., the wife of E. C. Hughes, M.A., M.C. Cantab., F.R.C.S. Eng., of a son.

SANDISON.—On August 16th, at Wildfell, Kingsdown Avenue, South Croydon, the wife of Alexander Sandison, M.B., of a son.

Marriages.

BOWEN—CLARK.—*On the 8th inst., at Christ Church*, Harrogate, William Henry Bowen, M.S., F.R.C.S., Lensfield Road, Cambridge, to Kathleen Edith Clark, Park View, Harrogate.

PENNY—PORTER.—On October 7th, at Christ Church, Cockfosters, Middlesex, by the Rev. —. Hobson, Charles Harry Greville, R.A.M.C., M.R.C.S., L.R.C.P., L.D.S. Eng., son of C. Hall Penny, Esq., M.D., Perran, Lancaster Avenue, Hadley Wood, N., to Kathleen Elsie, second daughter of Mr. and Mrs. John Porter, Ravenhill, Greenisland, Co. Antrim.

W. E. T.

GUY'S HOSPITAL GAZETTE.

VOL. XXVIII., No. 688.] NOVEMBER 7, 1914. [SIXPENCE.

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Passim.

SINCE the war began we have received letters from France dealing with the arrangements made for the care of the wounded. Two are printed in this issue. The first letter is of a very gloomy character, and has been heavily dealt with by our censor. Only those upon whom the burden of these matters falls and who are actually in touch with the obvious difficulties can fully appreciate the existing defects and suggest the necessary remedies. Alarmist reports and arm-chair criticism must be carefully avoided. During the rapid retirement of the allied forces there was a great amount of delay in transmitting wounded to hospitals for final treatment. In addition to the strain on the railways, many men and ambulance material had to be abandoned. The fact that Paris was in danger of being besieged prevented the reception of wounded there on a very extensive scale. When the offensive was resumed, and also during the recent heavy fighting, the medical authorities have to deal suddenly with very large numbers of wounded. It is also clear that only a just proportion of British wounded can be transmitted by trains, so that a certain amount of delay is unavoidable.

Operations are carried out over such an extensive area that it is not always possible to foresee where medical aid will be required most urgently, hence there may be comparative slackness in one part and too much work in another.

The second letter, written at the end of last month, is much less pessimistic, and on the strength of this and other reliable information received, a much more cheerful view is justified than was possible earlier in the struggle. We feel sure that all existing defects are being carefully remedied, and although the arrangements can never be perfect, they will in the end reflect great credit on those responsible for their working.

THERE is at least one point however which is worthy of attention. We feel that, in addition to making a few appointments for well-known and leading members of our profession, the Government should remember that there are many highly skilled surgeons of a younger school with very great experience who cannot give their services to the country at present. If, as has been suggested, there is not enough of the best surgical talent available for the wounded, it is surely advisable to secure the services of a number of younger surgeons at a remuneration which would enable them to leave their practices without jeopardising the existence of their dependants, or destroying the result of many years' sacrifice and hard work.

WE learn with great pleasure that accommodation has been provided in the Hospital for wounded officers. It is very appropriate that Stephen ward, which was recently reopened by Lady French, should have been chosen to accommodate them. The Hospital has every reason to congratulate itself on the quick and

efficient manner in which these arrangements were made. The Superintendent was informed on Monday morning last that there was a shortage of beds. The medical cases in Stephen were transferred to other wards, and, thanks to the Works Department, cubicles, similar to those in Bright Ward, were constructed. In the evening everything was quite ready, and the first batch arrived at seven o'clock. Most of the injuries were due to shrapnel wounds received during the recent fighting for the Straits of Dover. During the week there have been fresh arrivals daily. Thus, in addition to doing our duty to the civil population, work which will appeal strongly to the imagination has been provided.

Owing to the fact that there are not sufficient Nurses to take care of the French wounded, a committee organised by Mrs. Bedford-Fenwick has been raised "The French Flag Nursing Corps" and only those who have had at least three years' training have been allowed to join. Assistance was urgently required, and as a result the Hospital has lost the services of Sisters who have worked here for so long that it is difficult to know how long we shall get along without them. We trust they will return to us when the War is over. The fourth unit consisting of Miss Kipley (Sister Lazarus), Miss Lear (Sister Esther), Miss White (Sister Surgery), Miss Todd and Miss Finlay sail for France on the 12th of November.

Miss Daniels (Sister Ruth) left the Hospital on November the 4th, with a party of Guy's Nurses to take up a War Office appointment at Southampton.

The new members of the Resident Staff assumed their duties on November 1st. Mr. A. Wills (Dr. Beddard's H,P.), Mr. Danby (Sir A. Fripp's H.S.), Mr. Blake (Mr. Steward's H.S.), and Mr. Stallmann (Junior Charity). Mr. E. S. Taylor, who was appointed H.P. to Dr. Hale White, has resigned in order to join the French Red Cross.

Mr. E. D. Scott (Dr. Shaw's H.P.), and Mr. C. H. Gould (Sir A. Lane's H.S.), have been elected President and Vice-President for the next three months.

There will be no Residents' Theatricals this year, but the Niggers, under the direction of Mr. E. W. Blake, will be with us as usual, and have already commenced their practices.

Two interesting and valuable additions have recently been made to the Guy's Museum of Antiquities. A walking stick and a gold ring belonging to Thomas Guy were discovered in the Counting House and presented to the Museum by the Governors. These interesting mementoes were in the hands of the late Mr. Williams for fifty years, and in those of Mr. Shattock his predecessor for over forty years. Mr. W. Wale has been appointed Honorary Curator of the Museum until the end of December, 1915.

The executors of the late Dr. Pye-Smith's Will have presented a number of valuable books to the Wills' Library. A list of these is published in this Gazette; old books are always interesting, but the knowledge that they were collected by a man of such great literary attainments as Dr. Pye-Smith will enhance their value very much. We hope to publish very soon a bibliography of the published writings of Dr. Pye-Smith.

We have received a letter on behalf of a Belgian dentist, now a refugee in England, who is entirely without means and is anxious to get something to do, instead of being dependent on others. He is qualified as a Belgian dentist and has two daughters, one of whom, being also qualified, is able to assist in the surgery. Unfortunately he cannot speak English. Will any Guy's man who hears of any opportunity presenting itself kindly communicate with the Gazette?

We have been informed by the Dean that over one hundred students, all unqualified, are now absent on active service.

Errata in last Gazette.

Page 399, column 1, line 25.—*Iodine* should be *alcohol*.

Page 409.—Royal *Naval* Medical Corps should be Royal *Army* Medical Corps.

War and the Professional Classes.

Formation of a Relief Council.

DIRECTLY the war broke out the distress expected to arise therefrom among the Industrial population was at once anticipated and taken in hand to be dealt with adequately by the National Relief Fund. The response to the Prince of Wales' appeal was immediate and generous, with the result that there is little fear of irremediable upheaval of conditions among the Industrial classes.

This Fund, however, as everyone knows, makes grants only to the Local Distress Committees and the Soldiers' and Sailors' Families' Association. It does not, therefore, touch in any way the great distress already prevalent among the Professional Classes, for men and women of this class cannot appeal for help to the Local Distress Committees who possess no adequate machinery for dealing with such cases.

Yet this class is the one most promptly and severely hit by the dislocation of business, and by the sudden unexpected cessation of the demand for luxuries. In fact, not only are all the professions which depend upon the conditions of peace and the fluency of the market practically at a standstill, but also the creative and artistic professions such as Literature, Journalism, the Stage, Art, etc. All these rely upon the conditions of peace or the demand for luxuries, and that demand is gone. However long the war may last it is certain that the dislocation in the professions will continue for some years after peace has been made.

Many small but hitherto prosperous homes will be broken up through the mainstays being thrown out of work, or through the men, moved by the needs of their country, having enlisted as ordinary privates, receiving, of course, as such the ordinary pay of a private. This is, naturally, insufficient to keep the home together on anything like the standard of living that has hitherto been attained. In many cases, also, financial difficulties may arise because securities cannot be realised, or loans negotiated.

It is obvious, then, since there is no control organisation or general Fund to meet a distress already so prevalent that the need for such a Fund is very great.

During the last few weeks, therefore, there has been in process of formation an organisation to be called the Professional Classes War Relief Council. This Council is composed of the nominees of the majority of the principal Professional Institutions, such as Architects, Surveyors, Engineers, Musicians, Authors, etc., etc., as well as representatives of the chief Societies engaged in relief work (in order to promote valuable co-operation), with the result that it is a very representative and powerful body of business men and women.

The Council does not propose to offer any form of charity in relief, as this would naturally be both impossible and undesirable, but it does propose to give certain centralised forms of assistance which will, it is hoped, tide over the critical period of the war, enabling people so severely hit to resume their normal status when the war is over.

The majority of the Professional Societies have their own benevolent funds. These are and must remain quite independent, but it will ensure the most adequate return for outlay being obtained if certain forms of assistance are centralised and made available for their use.

The chief forms of assistance arranged are in matters of Education, Training, Emigration, Maternity Aid, and Temporary Employment, all of which are worked under separate representative sub-Committees of men and women whose positions and capabilities fit them especially for dealing with their special departments. For example, the Education Committee is composed of the Presidents of the principal Scholastic Associations, and has as its objective the arrangement of co-operation with the proprietors and governing bodies of schools by which children, whose parents, through financial stress are unable to pay the usual school fees, will be maintained at school at reduced fees assisted by a grant from the funds of the Council, thereby ensuring both the continuity of the schools, many of which would otherwise have to close down owing to the withdrawal of pupils, and also the uninterrupted education of the children, which is so vitally important to the national life.

The Training and Education Committee proposes chiefly to arrange free training for those professions for which it has been ascertained that openings exist, either at home or in the Overseas Dominions. This will apply mainly to men and women in already overstocked professions. Numbers of Domestic and Emigration Colleges have offered free or greatly reduced trainings to the Council, and these scholarships are immediately available.

The Maternity Assistance Committee proposes to open a Maternity Nursing Home for wives of professional men, staffed by voluntary doctors and midwives. A suitable building has already been generously lent for the purpose. It is also proposed to give free maternity assistance in their own homes, so long as those homes can be kept together. This Committee and Staff comprise some of the most eminent men and women in the medical world.

The Temporary Employment Committee has been organised to develop opportunities for temporary employment in works of public and national utility, both for men and women.

It has also been found necessary to meet the demand for immediate relief while people are waiting to

be placed in permanent work. The Women's Emergency Corps and the National Union of Women's Suffrage Societies have opened certain temporary work rooms for needlework, toy-making, etc., for professional women which they have arranged to make available to nominees of the Council.

It will be seen how far reaching and important the work of this Council is, for it affects not only the conditions immediately confronting us while the war lasts. It may develop on such lines as would be of permanent value in forming a centre for all information relative to the conditions and opportunities of employment in the various professions.

It is necessary to form a central fund to carry on this great work, this fund being used to organise and maintain the various forms of assistance proposed; to help those members of professions which are not organised and have, therefore, no benevolent funds; to provide assistance for the families of professional men who have given up all to enlist for the service of their country.

All those who have this very real need at heart are earnestly invited to give practical support by sending donations to the Treasurer, Professional Classes War Relief Council, 13 and 14, Prince's Gate, S.W. Cheques to be crossed Messrs. Coutts & Co.

France Again.

PARIS, October 5th.

IT was, I think, Alphonse Daudet who described Paris under the siege as "*La plus agréable des villégiatures*," and this time it seems as if history is going to repeat herself. A town of closed shutters and barred *persiennes* —a town where the footsteps echo in the empty streets, where the casual passer-by eyes one with a curious, frightened stare, a vast deserted ant-hill—this is Paris in the great war. Happily one sips one's *aperitif* in the cafés of the elect; there is no man to say you nay. Standing in the highway of the Place de l'Opéra, the unwary avoids with easy scorn the solitary taxi. The gay city—save the mark!—is making up for arrears of tranquility. After a while one comes to regard the silence and desertion as the normal state, and wanders round the monuments and boulevards with something of the adventurousness of the schoolboy who has been "kept back" when all the rest have left for home. A walk this morning down the Rue de la Paix reminded me of South Kensington on a wet Sunday. Well, well! "*et in Arcadia ego.*"

But there is one thing that livens the life of the Parisian, and that is *la croix rouge*. Without it the occupation of nearly all of us would be gone. There is none of the unpleasant regard to the practical that characterises, say, the work of one of our own probationary dressers. If you are young, move in good Parisian circles, and are willing to pay 3 frs. per day, or 300 frs. down for the duration of the war, you are entitled to wear a becoming uniform and the official "*brassard*," and pose interestingly before the delighted gaze of the sick and dying.

Before the Germans got too near for comfort, fashionable *demimondaines* drove in the Bois and the Avenue des Champs Elysées in all the paraphernalia of a very untrained nurse—perhaps they are still doing it—at Bordeaux. For the rest the membership of the Croix Rouge entitles you to drive at ghastly speeds regardless of the public or the wounded who may be unfortunate enough to be in your vehicle. The gibe that —(*excision by our Censor*)—were the two worst plagues of Africa might be repeated here in all truth.

Apart from these minor crosses the life of Paris is that of some sleepy township *en province*. The Taube monoplane, whose daily arrival enlivened the lives of the population, ceased its visits the day before I came over, so now we simply sit and wait for the papers which announce to us in mournful numbers that the situation remains good, and that the Allies are pushing on the right or left wing as the case may be. Just now people are coming back slowly, and we expect the Government every day; possibly its return will be as sudden as its departure, and we shall wake to find the walls plastered with posters of the joyous news. All the cafés close at eight and the restaurants at nine, so that anyone who does not go to bed is reduced to walking in the Champs Elysées and watching the searchlight on the Eiffel Tower. *Non, ce n'est pas toujours gai, la vie parisienne.*

And now for the hospitals. These may be divided up roughly into those under the English and the French Red Cross societies, the English military hospitals, and those run by other countries, such as the American ambulance at Neuilly. The first two are lodged for the most part in the larger hotels: the Bristol where King Edward used to stay, Claridge's in the Champs Elysées, the Astoria, the Majestic, where I am lodged for the moment, are all utilized for this purpose. For the most part they serve it admirably, the large entrance halls as secretarial offices and reception rooms; the dining rooms, ball rooms, lounges, and smoking rooms, make cheerful and airy wards, where the wounded Tommy can feast his eyes on mural decorations of Venus and Cupid, and statuettes of nymphs surprised by a centaur. The staff revel in luxurious bedrooms with sitting and bathrooms attached, and the dressers wake every morning in canopied four-posters. As yet I have not seen the English military hospital at Versailles, so perhaps the Editor will allow me to describe it in a subsequent paper. Most of our cases here are shrapnel wounds, for the most part extremely septic, many gangrenous. . . . (*Excision by our Censor.*)

The authorities, moreover, are extremely anxious to keep Paris comparatively free from wounded. . . . . The result is that here there is accommodation and to spare, many more doctors, dressers, nurses, orderlies, than anyone knows what to do with.

At Dieppe, I am told on unimpeachable authority, there are some six hundred wounded under the care of two military doctors, one trained nurse, and a few volunteer helpers. At Limoges six doctors had the care of five thousand, and here in Paris they told the young doctors who arrived a couple of days ago at the Hotel Astoria that they would have to wait for several days before they could find them anything to do. . . . .

G. H. F. G.

Pass List.

Conjoint Examination.—Final.

MEDICINE.

H. S. Groves. F. E. R. Laborda.
*G. W. King. B. Sampson.

MEDICINE AND SURGERY.

*W. H. Nicholls. *W. A. Young.

MEDICINE AND MIDWIFERY.

*S. S. B. Harrison. H. O. F. Thompson.

MEDICINE, MIDWIFERY AND SURGERY.

*J. F. H. Stallman.

SURGERY.

L. R. Broster. *D. C. Scott.
*A. Abdel-Al. *J. E. Davies.

MIDWIFERY.

*F. H. Dodd. H. G. Dresing.
E. J. Cooke. R. A. Holmes.
N. E. Kendall. A. F. Rook.
R. Curle. S. W. Coffin.
C. C. G. Gibson. J. H. Parry.

SURGERY AND MIDWIFERY.

R. Sells.

* Denotes completion of examination.

Society of Apothecaries of London.

SURGERY.

J. Stephenson.

MEDICINE.

J. Stephenson.

FORENSIC MEDICINE.

A. J. Fradersdorff. J. Stephenson.

MIDWIFERY.

J. Stephenson.

The diploma of the Society was granted to J. Stephenson enabling him to practise in Medicine, Surgery and Midwifery.

BOOKS, ETC., RECEIVED.—The Clinical Journal, The Hospital, London Hospital Gazette, M. S. Journal, New York State Journal of Medicine, Nursing Times, The Prescriber, Polyclinic, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—In a number of the GAZETTE published early in the year was a letter, with a grumble in it, regarding the condition of the Fives Court. Some, perhaps, of the Fives players are now on active service; but in the name of those left behind, who still wish to continue to play the game and to keep fit, I venture to place the following facts on record. Many men, having a free hour in the middle of the day, especially on Tuesdays, Thursdays and Saturdays, when the baths are open, wish to spend it, not only in feeding, but also in exercising themselves.

Some go to the Fives Court, and see there a court which *may* have been swept and garnished, and have had the devil of dirt exorcised once upon a time, but which now is in full possession of seven other devils of dirt, each equally as bad as the former. And the last state of that court is worse than the former. Naturally, those who come to see what the court is like, do not get their game.

Entirely disregarding the question of roofing and artificially lighting the court (questions which, at the same time, need an answer from those responsible), surely it is not too much to ask that a "squeegee" be provided with which those who wish to play can expel "undesirable aliens," in the form of water, soot and dirt generally.

At the time of writing, the court is not in a state in which a game of Fives could be played with comfort; and there might be the possibility of a ball in play being lost through hiding itself in one of the heaps of dirt.—I remain, Sir, yours sincerely, V. K. D.

Guy's Hospital. S.E.
October 13th, 1914.

DEAR SIR,—With regard to Mr. Philip Turner's plea for the greater use of Picric Acid, the chief reason against its use seems to be its great explosive capabilities. Of course, it is used in many forms of shell, and in the very portable crystaline form is extremely dangerous. I believe that in any degree of dilution in which it retains its full antiseptic properties, it is unwise to handle it roughly, and there are certain regulations with regard to its sale and carriage.—Yours sincerely, O. G. MORGAN.

October 26th, 1914.

The Work of the Special Reserve.

SOME notes on the work at a R.A.M.C. Training Centre may be of interest to Guy's men thinking of joining the Service. The job to which a man may be put by the War Office seems difficult to forecast, but it seems likely that a large proportion in the future, both of civil surgeons and of Special Reserve officers will be posted to such centres. These notes refer to the centre at Tidworth Park, Salisbury Plain, but probably apply to the others, of which there are four or five of about the same size. This centre consists of three sub-divisions, each under a R.A.M.C. captain. These and the quartermaster are the only regular officers. Each of the three sub-divisions contains five field ambulances, the full complement of a field ambulance being 250 (including A.S.C.) and ten officers. At present we have here only 200 and three officers to each. Each field ambulance has three sections, with tent and bearer sub-divisions; so that every officer now receives almost on the day he arrives the command of a section of 60 men, who are for the most part recruits, with a leavening of old re-enlisted R.A.M.C. men. The work, both present and prospective, is almost entirely non-medical: at present drill, in the future transport, comprises practically all we have to do. There is first-aid treatment—now in instruction, later in practice—but except in emergency a field ambulance is not expected to do more. The eager surgeon is met by the chilling fact that statistics show better results when he does not interfere. At first this is rather discouraging, but one very soon gets reconciled to doing the work which most urgently wants doing. Nor is the work by any means uninteresting; the machine of military discipline imprints a certain stamp on everyone, which, if not overdone, is very beneficial; and officers receive it in the pleasantest possible way. We expect soon, moreover, to be able to leave the drilling to N.C.O.'s, and spend our time more in learning up methods of organisation and administration, as well as operative tactics in the field The best man is given the best job, here as elsewhere, and there is ample scope for his talents.

At Tidworth we are under canvas, officers two to a tent, with a mess-room for meals and sitting in. Each has a servant. We hope in a few weeks to have our mounts, but no horses or transport have as yet arrived. Some units are in barracks, some in huts; possibly we shall be moved to one or other before long. We have had a good deal of rain lately, but do not suffer much. It is very much easier to go out of the tent to a cold bath on a rainy morning than on a cold morning, as it was at the beginning of October. Reveillé is at 6; there are four daily parades, at 6.45, 9.10, 10.30 and 2; and at 4, as a rule, work is over for the day. Saturday afternoons and Sundays are free; one week-end in four is allowed off. On wet days parades are suspended, and as far as possible we give lectures under cover, or receive them ourselves from the C.O.: some enthusiasts, such as Lieut. The Gull Student, organise voluntary runs on wet afternoons.

The training course is expected to last about four months: but our movements depend entirely on the infantry divisions to whom we are attached. When they are ready and want us, we go. I can say without any hesitation that a man will score enormously by having some training such as this before going to the Front: the life even here is so complete a contrast with civilian work, that the conditions of field work must be almost intolerable without some intermediate acclimatisation. Moreover, one need hardly say, the training leads to a very great increase in fitness and efficiency for officers as well as for men. Civil surgeons come here, as well as Special Reserve officers. It seems that the medical opportunities of service are of two very distinct types: field work such as this, without purely medical or surgical duties; and base hospital work, without any experience at all of actual active service. Those are the alternatives; the intermediate grades are difficult to get, and less satisfactory, because less thoroughly organised. There is also the regimental work (in which Lieut. Hopkins lost his life), which is difficult and dangerous, but affords unparallelled opportunities for the man who wants excitement. It belongs to the first ype, in not offering purely clinical experience, but it would require very great practical ability in connection, for instance, with a typhoid outbreak. I believe it is given, rather indiscriminately, to civil surgeons.

However, the object of these notes is only to shew the man who joins the Special Reserve what he is likely to have to do—four months' training, under canvas or in huts, with and over Kitchener recruits: with the prospect then of going to the Front as part of a fully equipped and efficient field ambulance, with men and officers whom he has trained with and knows, to work with the first line of communications in transporting the wounded back from the fighting line. He will perform, and superintend, first-aid treatment, but rarely do any more. He will be placed at once in a position of command, and have four very pleasant and healthy months of camp life to train him and harden him for his duties in the field. With a war lasting as long as the present one promises to last, it is likely that even after four months he may yet see quite as much active service abroad as he will want.

T. B. HEATON.

Gazette Special Pathologist.

S. C. C., MARTOCK.—This specimen is a squamous epithelioma of the lip in an early stage. It presents epithelial ingrowth from the epidermis with invasion of the underlying tissues, surrounded by a marked inflammatory reaction.

PATHOLOGIST.

Glycosuria and Diabetes.

TWO CLINICAL LECTURES BY

W. HALE WHITE.

GENTLEMEN,—Inasmuch as the diagnosis of diabetes depends upon the detection of dextrose in the urine, we may first devote a few minutes to this. In this country Fehling's test is almost the only one used in ordinary everyday practice, but mistakes sometimes occur because the solution has been kept too long, for then a brick-red precipitate may appear on boiling when no sugar is present. I have to examine many hundreds of life insurance reports; often the statement is made that the proposer has a trace of sugar in his urine, but is otherwise healthy. It would be interesting to know how many of these people become diabetics. Certainly at the time they are examined the presence of the reducing body is often only temporary. As far as the facts we have go, a good many do, for, according to some New York actuarial figures, among a large number of persons accepted for life insurance at normal rates, but who had had sugar in their urine found on one occasion only, the mortality from diabetes was six times the normal, although these were exceptional lives, otherwise they would not have been taken at normal rates in spite of sugar having been found once. No doubt, in several the reducing agent is not dextrose. It is often glycuronic acid, uric acid, or urates; it may be other sugars, *e.g.*, maltose or arabinose, a pentose which has nothing to do with diabetes, even a suckling woman passing lactose in her urine has been said to have diabetes, and people passing these various bodies which are not dextrose have before now been subjected to irksome and unnecessary diabetic treatment. Then, too, perhaps, there may be some persons who are quite healthy, but, nevertheless, their sugar tolerance is unusually low, that is to say, they get glycosuria after taking less than the 150 grammes of dextrose which is the amount which can be taken on an empty stomach by most persons without producing glycosuria. Such is likely, for we know that even on ordinary diet minute amounts of sugar are contained in the blood and excreted in the urine although the gramme a day that occurs there is too small an amount to be detected by the ordinary tests.

It is stated that glycosuria means hyperglycæmia. Certainly this is almost always true, but there are a few persons who excrete 1 to 5 grammes of sugar a day who have not hyperglycæmia nor any symptoms of diabetes. They may be suspected when it is observed that restricting the carbohydrate intake does not do away with the glycosuria. It has been suggested that this variety of glycosuria is allied to that caused by phloridzin, there being some body in the blood which increases the permeability of the renal cells to dextrose. Salomon* has contributed to our knowledge on this subject. He records several cases, and points out that the appearance of the sugar usually begins during the second or third decade, generally very little sugar is excreted, and it bears little or no relation to the carbohydrate intake. These young subjects are often nervous.

Each apparently healthy person whose urine gives a slight or suspicious reduction with the copper test should be (1) questioned as to the amount of sugar recently taken; (2) questioned as to any drugs taken; (3) examined to see if disease or condition known to lower sugar tolerance is present, *e.g.*, pregnancy or exophthalmic goitre; (4) it should be observed whether taking less carbohydrate controls the glycosuria; and (5) he should have the same specimen of urine examined by the fermentation and phenylhydrazine tests, for by these all reducing bodies except dextrose and lævulose can be excluded; the separation between them is not necessary for the diagnosis of diabetes in which both may be passed. It must be the same specimen, because probably in the early stages of diabetes sugar is not constantly present in the urine. When a patient has once passed sugar, and the doctor finds the urine free from it, he must ascertain what diet the proposer is taking.

We will now briefly consider the causes of glycosuria, and will take first the organs, the internal secretion of which, when excessive, causes, glycosuria or, in other words, lowers the tolerance of the body for sugar; such organs are the thyroid, the pituitary, the suprarenals, and possibly the organs of generation.

The Thyroid.—The effect of the excessive secretion of this gland in occasionally leading to glycosuria is well seen in exophthalmic goitre

* "On Harmless Diabetes of Young People, together with a Contribution to the Question of Renal Diabetes," Deutsche Medizinische Wochenschrift, 29th January, 1914.

or Basedow's disease, and Cramer and Krause* have shown that in dogs the tolerance for glucose is slightly diminished by thyroid feeding. The frequency of glycosuria in this malady cannot be stated, for unless the urine of many cases were examined daily slight examples would be missed. The glycosuria may pass away as the exophthalmic goitre gets better. For example, a girl, aged 21, had exophthalmos, tachycardia, large thyroid, tremor, and diarrhœa. Six months later glycosuria appeared; soon after this she began to improve, the glycosuria persisted two years, but by the time it left her she was so well that she could walk eight miles. Seen twelve years later, she said she had been perfectly healthy all this time; there was no glycosuria. On the other hand, I know of three cases of exophthalmic goitre that have died from diabetes. 1. A man, aged 40, had exophthalmic goitre for years, but glycosuria was only noticed twelve months before I saw him; during all this time it persisted, although the exophthalmic goitre improved, so that now hardly any evidence of it could be found; he died from diabetic coma a few days after I saw him. 2. A woman, aged 31, had a large thyroid, great tremor and tachycardia, and some exophthalmos. She improved greatly under rest, and eyes and thyroid became almost normal. Eight years after I first saw her she was found to have diabetes, from which she died in two months. 3. A woman, aged 41, known to have had diabetes and slight exophthalmic goitre for eight years, was admitted into the hospital and died soon after in diabetic coma. We learn from these cases that sufferers from exophthalmic goitre may die of diabetic coma, and the strange fact that the glycosuria may appear, continue, and even end in diabetic coma although the exophthalmic goitre is improving and the thyroid has become of almost normal size. Medicinal administration of thyroid may cause glycosuria, and I see no reason why it should not lead to diabetes, and I have heard of a case in point. Anyhow, it is desirable, when sufferers from myxœdema are taking thyroid regularly, to test the urine from time to time, and to limit the doses of thyroid so that glycosuria does not appear. As might be expected, sufferers from myxœdema have a high sugar tolerance, but a few cases have been recorded of glycosuria associated with myxœdema, but in some at least there is doubt as to the correctness of the diagnosis. There is no evidence as to how the thyroid lowers the tolerance for sugar so as to lead to glycosuria; it has been suggested that it acts through the pancreas.

Pregnancy may be accompanied, not only by the excretion of lactose, but by the passage in the urine of dextrose in a small amount even when the woman is on ordinary diet. We know that the thyroid hypertrophies in pregnancy and perhaps the presence of dextrose in the urine is due to this.

The Pituitary.—The colloid secretion of this organ, which passes into the general circulation, in some animals at least, going first straight into the cerebro-spinal fluid, excites glycosuria by lowering sugar tolerance; hence when, as in acromegaly, we have enlargement of the anterior lobe of the pituitary body, this by its pressure on the colloid secreting cells excites them, and so leads to an over-production of their secretion causing a low glucose tolerance, and consequently glycosuria, and, in a severe case, diabetes; but, acromegaly being rare, this variety of glycosuria is not of the same clinical importance as that of exophthalmic goitre. It is of interest that the pars intermedia of the pituitary and the thyroid have the same structure; both secrete colloid material, and an over-secretion of either lowers sugar tolerance and causes glycosuria; on the other hand, the destruction of either, as in myxœdema and hypo-pituitarism, causes an increased sugar tolerance. If pituitary extract were employed therapeutically for long periods we should expect to meet with glycosuria as a result. In some animals it has followed the injection of pituitary extract. The pituitary body enlarges during pregnancy, and perhaps the rare presence of dextrose in the urine during pregnancy is due to an excess of the secretion of the pars intermedia.

The Adrenals—It is well known that adrenalin, which is constantly being poured into the blood from the adrenal medulla, tends to lower glucose tolerance, and the same is probably true of the secretion from all the chromaffin tissues of the body. As far as I know there is no certain instance in clinical medicine of glycosuria due to increased secretion of adrenalin, but it is given with great success in asthma, and it behoves us occasionally to test the urine of those taking it, for it may possibly lead to glycosuria. Some think that as age advances, all the chromaffin tissues become more active, and by this explain the high tension pulse often seen in persons well past middle

* Proceedings of the Royal Society, B., vol. 86, 1913.

life. Garrod suggests that some examples of the mild glycosuria of elderly people are due to the same cause.

The Organs of Generation.—Very little is known of the influence of these on sugar tolerance, but glycosuria has been observed in disease of the female organs of generation; *e.g.*, ovarian tumours; and it has disappeared when the surgeon has removed the tumour. It is possible that the occasional presence of dextrose in the urine of pregnant women is in some instances to be explained by an internal secretion from the organs of generation.

We now turn to organs the internal secretion of which constantly restrains glycosuria; therefore, if the internal secretion is greatly diminished the tolerance for sugar is sufficiently lower for dextrose to be passed in the urine on an ordinary diet. There are two such organs: the pancreas and the parathyroids.

The Pancreas.—When this is almost or completely destroyed, its internal secretion is sufficiently reduced for glycosuria and diabetes to occur. This is a most important cause of diabetes, and I find that in fourteen consecutive years at Guy's Hospital there were 6708 post-mortem examinations, and that the pancreas was to the naked eye diseased in 142 of these, or in about 2 per cent. of all persons dying in a large general hospital. It was called atrophic or small in 19 cases; 16 of these had diabetes, and a quarter of all the patients dying from diabetes in Guy's Hospital have a small atrophic pancreas. Other pancreatic diseases will cause it, but they must destroy most of the gland. On the other hand, patients may die from diabetes and yet the pancreas may appear perfectly healthy even after histological examination; perhaps these cases are dependent upon disease of other organs influencing sugar tolerance.

It is very difficult to diagnose chronic pancreatitis in any case of diabetes, but there is an impression, probably correct, that it is more likely to be found if the diabetes is severe. Lately it has been suggested that cholangitis, usually the variety associated with gall-stones, may cause glycosuria because the cholangitis, by spread of inflammation, leads to chronic pancreatitis, and cases have been recorded in which glycosuria had disappeared after the gall-bladder has been drained. But the figures taken from the post-mortem room at Guy's Hospital do not afford much evidence of a causative relation between gall-stones and diabetes. I find that in the post-mortem room, among 15,000 consecutive post-mortem examinations gall-stones were found in 476, or once in every 32 deaths; 121 of the 15,000 died from diabetes, so that on the theory of chance four of these should have had gall-stones, whilst, as a matter of fact, 11 had, but the difference between 4 and 11 is not enough to be very convincing—that between 40 and 110 would have been much more so—especially as many of the diabetics died before the age at which gall-stones are likely, for Pavy found that among hospital patients the usual age of death from diabetes was between 15 and 40, but the age of nearly all the sufferers from gall-stones exceeds 40. Further, that gall-stones have much influence in the production of diabetes is unlikely, for they are much commoner in women than in men, but diabetes was three times as common in men as among women. It has been suggested that the chronic pancreatitis associated with diabetes may be due to inflammation of the duodenum spreading up the pancreatic duct and sometimes to arterio-sclerosis, but I have already mentioned the suggestion that an excess of adrenalin causes both glycosuria and high blood-pressure.

The Parathyroids.—These have, by experiments, been shown to have the same relationship to glycosuria as the pancreas, for excision of them in dogs causes it, but, as far as we can tell, this fact has no application in medicine.

The Influence of the Nervous System on Glycosuria.—It has been known for a long while that disorders of the nervous system will cause glycosuria; indeed, rather over thirty years ago it was urged by some that diabetes was a disease of the nervous system. Sugar has been found in the urine in association with meningitis, cerebral tumours, and other organic nervous diseases. It may if carefully sought often be found after severe concussion. Cannon* and others have shown that glycosuria appears in cats if they are frightened by a dog, and Folin† and others have found a small amount of sugar present in the urine of a considerable proportion of insane persons (22 out of 192); the great majority of them suffered from depression, apprehension, or excitement. Further, they found that 17 or 18 per cent. of students, both male and female, passed small amounts of sugar after the emotional strain of an examination. There are many interesting differences in the incidence

* Amer. Journ. of Physiology, xxix., p. 280, 1912.

† Journ. of Biological Chemistry, xvii., No. 4, p. 519, May, 1914.

of diabetes which have not been proved to be due to differences of the nervous system, but which it has been suggested are due to such differences, and, therefore, we may as well consider them here. There is the alarming frequency of diabetes in certain races of men. For example, it is stated that among the educated and commercial classes in India no less than 15 per cent. of persons between the ages of 40 and 60 habitually excrete a pathological quantity of sugar in their urine, and this eventually leads to diabetes in most cases. I know a native doctor in India who has sugar in his urine whenever he has been at work for some months, and this he attributes to the worry of a large practice, for it always disappears when he takes a holiday, even if he makes no difference in his diet.

Of the races who live in India, diabetes is more common among the Hindus than among the other races, and the Hindus are said to be more emotional than the others. Dr. A. Caddy finds that among the Europeans in India 0·61 per cent. proposing for life insurance are rejected or loaded for glycosuria, while among the Bengalis the proportion is 3·24 per cent.* It is common knowledge that in Europe diabetes is more frequent among the Jews than Christians, and this has been ascribed, rightly or wrongly to the fact that the Jews are an emotional and intellectual race who tax their nervous systems more and their bodily systems less than Christians. That diabetes occurs in some families more than in others is undoubted, but whether this is owing to a family likeness of the nervous system is unknown. Otto May† has recently shown that the family histories of 1,143 cases of death from diabetes showed a death from diabetes in 41, that is, 3·6 per cent. A control investigation of 1,143 picked at random for the same period showed a positive family history only in twelve cases, that is, 1·05 per cent. It appears clear that when diabetes occurs in families it makes its appearance early in life, and it is that variety, the severe variety of diabetes, which is met with in these in the first half of life that tends to run in families, and Otto May's figures further show that probably the hereditary factor comes out more strongly in the male than the female.

It is interesting here to observe that while it has been suggested that the nervous system plays a part in diabetes, it is strange that it was, at any rate till recently, much commoner in men than in women. But during the last twenty-five years there has been in Great Britain and Ireland an extraordinarily rapid increase of the disease in both sexes, and the increase has been greater in women than in men, as the following figures show :—

	Deaths from Diabetes.		
	Male.	Female.	Total.
1890	1,236	908	2,144
1900	1,771	1,584	3,355
1911	2,345	2,349	4,694

We see that the number of fatal cases is now the same in women as in men and that while the total number of deaths from diabetes has increased very greatly in both sexes it has increased much more in women than in men. From 1890 to 1911 the increase in population has been from 38,000,000 to 45,000,000, while the deaths from diabetes have considerably more than doubled.

Generally speaking, glycosuria, undoubtedly due to disease of the nervous system, is clinically unimportant, for either the nervous lesion soon kills or the glycosuria is slight and transient. We know nothing for certain as to its mode of production in man, but because the secretion of adrenalin is under the control of the splanchnics, is has naturally been suggested that nervous glycosuria is really adrenalin glycosuria, and for this there is strong experimental evidence; or that, as the cervical sympathetic sends fibres to the pituitary, and excision of the superior cervical ganglion leads to glycosuria, all nervous glycosuria is really pituitary glycosuria ; or it has been thought to be due to influences reaching the liver through the nervous system and leading to a rapid transformation of glycogen into sugar.

The Liver.—Considering the importance of the liver as a storehouse for glycogen, it is strange at first sight that diabetes is a rare complication of organic hepatic disease, so rare that it is open to question whether there is an association of any importance. Perhaps this is begause, for hepatic disorder to cause diabetes. we should require an exaggeration of hepatic function like the exaggeration of thyroid function seen in exophthalmic goitre, and then, too, there are, besides the liver, other stores for glycogen which must quickly compensate for any deficiency of its glycogenic function, for in many hepatic disorders the hepatic glycogen is almost absent, *e.g.*, after obstruction to the

* Life Assurance Medical Officers' Association Report

† Life Assurance Medical Officers' Association Report, 1914.

hepatic duct Bernard's puncture will not lead to glycosuria. It is true that glycosuria has been occasionally recorded in cirrhosis, acute yellow atrophy, phosphorus poisoning, and other hepatic disorders, but whether in such cases it is disorder of the function of the liver which leads to the glycosuria is not proved. Although, if the liver is diseased, giving dextrose rarely leads to glycosuria, giving lævulose often does; a fact which some authors say may help in the diagnosis of hepatic disorders, but others deny this. It is only fair to state that some, especially the French school, consider that many examples of glycosuria, especially those of the mild variety seen in middle-aged or elderly people who are obese and over-eat, are due to a disordered hepatic function in virtue of which sugar that should be retained as glycogen is poured into the blood, and they urge that the liver is probably the cause of the hyperglycæmia, for it is often enlarged. That it is enlarged is certainly true, for these persons often have a fatty liver, but whether this should be regarded as the cause of the glycosuria is doubtful. On proper dieting the liver becomes smaller and the sugar disappears from the urine. It has been suggested that some forms of glycosuria may be of intestinal origin, but we have no clinical evidence of this.

We thus learn that there are many possible causes for the appearance of sugar in the urine, but in spite of this we must confess that very often, even after a post-mortem examination, we cannot say what was the cause of the disease in a patient dead of diabetes; nevertheless we are able to distinguish two clinical varieties. First we have the severe variety, the Diabetes avec Denutrition of French authors. In this disease the results of protein metabolism are abnormal, so that the amount of nitrogen excreted in the urine is excessive and the sugar in the urine is derived partly from that ingested, but also largely from the protein tissues and to a less extent from the fats, and it may persist even when there are no carbohydrates in the food. The urine usually contains a larger or smaller amount of oxybutyric acid, acetone, and diacetic acid. The patient usually suffers from symptoms of acidosis, the alveolar CO_2 is, in bad cases, much diminished, and he will almost certainly be much wasted and die of coma. He is usually under 40, the younger he is the worse the prognosis. This is the variety of diabetes of which several instances may be met in the same family. If anything abnormal is found post-mortem which has any bearing on the disease it is that the pancreas is atrophied.

The second variety is mild. In England it is often called alimentary glycosuria, in France Diabetes sans Denutrition. Here there is nothing abnormal about the protein metabolism, hence the excretion of nitrogen is normal in comparison with the diet, and the sugar in the urine comes exclusively from that in the food. Oxybutyric acid, acetone, and diacetic acid are not found in the urine. The patient does not suffer from symptoms of acidosis, and there is not any decrease in the CO_2 of the alveolar air. He is not wasted, but is often fat and over-fed; he does not die of coma, but he frequently suffers from arterio-sclerosis. He is usually over 50, and although death is rarely attributable to his glycosuria, yet he is not an average life. Alimentary glycosuria does not run in families. It is easily controlled by diminishing the carbohydrate intake, and at death the pancreas is not found to be diseased. The probable explanation of it is that as age advances the sugar tolerance is diminished. Many authors believe that in this variety the glycogenic function of the liver is at fault. The first variety may, in its early stages, be impossible to distinguish from the second, and, indeed, in many a case which ultimately becomes a severe case of diabetes, there is, at first, nothing wrong beyond the presence of sugar in the urine which can easily be controlled by diet as in alimentary glycosuria, hence the statement that the second variety may pass into the first, but I suspect that if we had more knowledge we should see that from the very beginning these two varieties are distinct, although it is only fair to add that probably the mere condition of hyperglycæmia is harmful, as is shown by the fact that it is universally agreed that it is wise to diminish glycosuria by restricting the carbohydrates in the food.

The second lecture will appear in the next number of the GAZETTE.

Change of Address.

F. J. Wheeler, from 95, Cambridge Road, to 41, Albert Road, Southport, Lancs.

Hal J. Henderson, M.B , B.S. Lond., M.R.C.S. Eng., L.R.C.P. Lond., from The Red House, Amersham, to Alwyns, Amersham.

Harold L. James, from Guy's Hospital to Beresford, Brighton Road, Purley, Surrey. Telephone, Purley 866.

Obituary.

GERALD GRACE,
L.R.C.P. Lond., M.R.C.S. Eng., L.M.S.S.A.

GERALD GRACE on September 15th, whilst driving his motor car near Springs, in the Transvaal, was shot dead by the police under extremely tragic circumstances. The Transvaal police were hunting down the Jackson gang of desperadoes, and unfortunately mistook his car for that of one of the desperadoes. It appears that Mr. Grace did not hear the challenge of the police to stop, and was fatally shot, his wife and daughter who were driving with him being both wounded. It will be recalled that General Delarey was, on the same day, killed under precisely similar circumstances.

Gerald Grace, who was in his forty-eighth year at the time of his death, was the second son of Mr. Alfred Grace, M.R.C.S., of Chipping Sodbury, Gloucestershire, and the nephew of Dr. W. G. Grace, the well-known cricketer. He entered Guy's in 1892, and after qualifying served as surgeon on the South African Union Line of Steamers, there making the friendship of the late Cecil Rhodes and Sir Starr Jameson. He was Civil Surgeon during the South African War, attached to the 83rd and 84th Battery of the Royal Field Artillery, and went with Lord Roberts's column from Bloemfontien to Pretoria. Later he was attached to the hospital at Johannesburg. He was awarded the medal with six clasps.

Gerald Grace was a man with a personality, and many Guy's men, amongst whom he was extremely popular, will recall how he excelled, apart from medicine, as an entertainer. He could give an entertainment, lasting over two hours, consisting of conjuring, musical sketches at the piano, humorous recitations in costume, and whistling. It goes without saying his services were often greatly in request in the cause of Charity, and it is probable there are not many parts of England in which he had not given entertainments.

At the conclusion of the South African War he married, and commenced practice at Springs, Transvaal, where he was recently elected Mayor. S. C.

Appointments.

Royal Army Medical Corps.

Mr. F. F. Burghard has been appointed Consulting Surgeon with the British Forces overseas, and has already left for France.

L. Milton to be Lieutenant, 2nd London General Hospital.

D. C. Scott to be Lieutenant, Special Reserve, Sheffield.

J. Stephenson to be Lieutenant, Special Reserve.

S. S. B. Harrison, Lieutenant R.A.M.C. (T.), 3rd North Midland Field Ambulance.

E. P. Minett, Captain R.A.M.C. (T.), 6th Field Ambulance, 2nd London Division. Seconded for duty in British Guiana to 1916.

E. W. Strange, Captain R.A.M.C. (T.), 3rd North Midland Field Ambulance.

G. F. Haycraft, Lieutenant R.A.M.C. (T., 3rd North Midland Field Ambulance.

Philip J. Watkin to be Temporary Lieutenant.

To be temporary Lieutenants: W. T. Wallis, M.B.; W. P. H. Munden, M.D.; T. P. Cole, M.B.; J. A. Glover, M.D.; Norman Reader, M.B.

Thomas G. Evans, M.D., Temporary Lieutenant, serving with the Welsh Hospital.

Indian Medical Service.

The provisional promotion of Captain P. S. Mills has been confirmed.

G. C. Covell has been finally admitted to the Service, dated January 31st, 1914,

Lieutenant C. M. Plumptre, I.M.S., to be Captain.

Lieutenant E. A. Penny, I.M.S., to be Captain.

Casualties.

Captain G. H. Rees, R.A.M.C., reported prisoner of war (previously reported missing).

Attached to other than Medical Units.

D. F. Small and D. A. Bevis, Artists' Rifles.

L. R. J. Hallett, 5th Royal Sussex (Reserve for Kitchener's Army).

J. A. S. Wright, Dresser, Church Army Hospital, Caen.

W. H. Turner, 2nd Lieutenant, Royal Field Artillery (Regulars).

Lieutenant Alan C. Ransford to be Captain,

Naval.

H. Millett, Temporary 2nd Lieutenant, Royal Marines.

E. R. Bailey and W. D. Galloway, Temp. Surgeons to the *Vivid*, additional for Plymouth Hospital.

G. E. W. Lacey, M.B., to the *Dominion*.

F. G. Lloyd, Surgeon R.N., H.M.S. *Victorian*.

R. N. Craig, Surgeon Probationer, H.M.S. *Lucifer*.

Leonard C. D. Irvine to the *Pembroke*, additional for the *Cornwallis*, on commissioning.

Civil.

A. R. Beaumont, F.R.C.S.E., M.R.C.S., L.R.C.P., District and Workhouse Medical Officer of the Uppingham Union.

B. R. Parmiter, M.B., B.S. Lond., Second Assistant Medical Officer, Lewisham Union Infirmary.

N. L. M. Reader, M.B., B.S. Lond., Assistant Medical Officer, Lambeth Parish Infirmary.

Harold Gardiner, F.R.C.S., Acting Assistant Surgeon, Royal Free Hospital, Gray's Inn Road, W.C.

F. J. Wheeler, M.R.C.S., L.R.C.P., has been appointed Honorary Medical Officer to North of England Children's Sanatorium, Southport; and Civil Medical Officer to Recruiting Office (Regular Army) Southport.

Papers by Guy's Men.

A. E. Boycott, and another: On the regulation of the Blood Volume in Normal and Nephritic Animals. Part III., Experiments with Tissue Fluid.—*Journal of Pathology and Bacteriology*, October, 1914.

R. A. Chisholm: The regulation of the Blood Volume in Experimental Nephritis.—*Ibid*, October, 1914.

Body Snatching and other matters.

PARIS,
October 29th, 1914.

In my last letter I think I made some reference to the difficulties experienced by all but the military hospitals in keeping their beds full. Since then the difficulty has increased tenfold, and at present *la chasse aux blessés* is almost the only sport the war has left us. Formerly we used as a decoy a young and charming Parisienne, who, daintily attired as a red cross nurse, would beard the grimmest and most harassed of *médecins en chef*, melt him in the irradiations of her smiles, and squeeze from his relenting grasp three or four wounded, who were carried off in triumph, to the infinite chagrin of the ten or twenty waiting ambulances. Alas! internal dissensions sprung up, and in tears our lady left us, to join a rival establishment. Since then no *blessé* worthy of the name has been secured, and we snatch eagerly at cases invalided for whitlows or sore feet; if things go on like this we shall have to close down in a fortnight. As the line of battle swings more and more eastward, fewer and fewer wounded will come by Paris, so that the casual stragglers that we pick up now will be deprived us, and we shall be forced to establish a base nearer the fighting line, or else set up somewhere on the Riviera, where it seems most of the serious cases are being sent.

These expeditions are always amusing if not invariably profitable. An ancient Charron, converted into a six-stretcher ambulance, contrives to carry four of us wedged tightly on the exiguous driver's seat. Our party consists of the worst chauffeur in Paris, one of the Staff of the British Red Cross, whose unofficial uniform is of the greatest service in impressing the natives, one of our surgeons, and lastly myself, whose function it is to wheedle, flatter, and cajole the local *commandant* into giving us whatever wounded he may have on his station. From my precarious situation on the foot-board I come in for most of the mud and blasphemies that the *insouciant* driving of our redoubtable chauffeur brings upon us, and on one occasion, at least, when we charged a heap of stones in the dark and left the motor perched like the ark on Mount Ararat, my dissolution seemed imminent. Even then our chauffeur was unruffled,—"*quelle aventure!*" was his only comment.

These body snatching expeditions give one a knowledge of the suburbs of Paris that would surprise the ordinary *boulvardier*. I confess that hitherto St. Denis had been no more than a name, and la Villette notable as the place where the Apaches came from. I pictured them vaguely as dim, twilight spots, with lurid bars and ball-rooms, where Apaches, male and female, loved, stabbed, and danced their stealthy saraband. Places resounding with death rattles, hoarse cries of passion, and all the rest of it. And now I have one illusion the less. Anything more forsaken, hideous, and utterly demoralizing than extra-mural Paris I would rather not think about. Beside it, Upper Tooting becomes a bright and cheerful residential district, and the fastnesses of Walham Green take on the qualities of a fairy city. These raids of ours start often enough at midnight, sometimes later, and guided by a sort of instinct we go first to one station, then to another, searching, but alas! so rarely securing the elusive *blessé*.

Last night, for example, most God-fearing Parisians were abed when the four of us packed tightly as the proverbial sardine, set forth on this errand of mercy, game of chance, call it what you will. A thin wisp of moonlight, covered now and again by slowly moving clouds, lent a touch of romance to the banalities of the rue Lafayette, and the mud and wine shops of the re-christened Avenue Jean Jaurès. Soon we reach the Porte Pantin, where a warmly muffled sentry stops us and demands our papers. "Beaux bas Valenciennes" I reply, and at the magic word he stands to attention and the car moves on. Looking back from my post of vantage, I see him gazing after us with weary eyes, then with a shrug he returns to the warmth of his fire, perhaps he thinks we are Germans in disguise. In a few moments we reach the station of Pantin, a dreary wilderness of a place, and demand the *médecin en chef*. A brief interview, and we learn that no wounded have passed through for three days—"at Aubervillers perhaps." So to Aubervilliers we go. Here at least there is life, and the blue twilight of electric arcs shows nurses, orderlies, surgeons, officers and slightly wounded, moving amid a miscellaneous collection of motors, ambulances, goods trucks, and all the lumber of a station yard in full activity.

The train has just arrived and even now some few wounded are being removed from the wagons, the gravest of all being given treatment in an improvised hospital by the sidings, others less serious, though bad enough in all conscience, are carried on stretchers to the central goods shed, where the commandant, aided by a large staff of excitable, bearded assistants, directs to what hospital they are to be sent. For some minutes we watch the unloading of these wagons. Preceded by orderlies the officer passes from door to door, entering some, and questioning briefly the men lying full length or setting in what comfort they can upon the straw-covered boards. As the panel slides back a fetid odour of pus and fæces reaches the nostrils; startled by the unexpected brightness a couple of horses tethered at one end of the truck stamp and whinney. Carrying an acetylene flare, which makes weird effects of chiaroscuro on the bare walls and floor, an orderly comes in and collects the histories of the men. One man, wounded in the head, persists in taking him for a German, the others laugh and point to their foreheads. A little further on, in second and third class carriages, men with arms in slings, and less serious body wounds, crowd in the corridors and clamour for food and drink. With admirable order and despatch women of the French Red Cross come round distributing bread, cheese, fruit, hot coffee, and milk. Near by, in two or three canteens, a

group of officers and surgeons discuss the latest phases of the war. Sipping a bowl of most excellent chocolate, I listen, till they begin to question me on the cases we have already in hospital—how many have died with tetanus, whether it was already developing when admitted, is the serum administered in all cases as a prophylactic measure? . . . . The general impression seems to be that the war cannot last long, the German losses are too enormous.

After a time we pass to the goods shed, and form one of a group around a huge charcoal brazier, one or two men on stretchers joking and drinking wine or coffee with the bearers, an endless bustle and scurry on the part of the doctors and orderlies. Stretching the length of the entire shed are three rows of improvised beds placed on sloping planks, and warmly covered with feather mattresses; as the wounded come in they are placed on these, and there await further examination. Few of the cases seem grave, most of the men are able to sit up and take a lively interest in their surrounds. At the far end a couple of Turcos produce some cards and indulge in a complicated game of chance.

In a siding within the shed a trainload of *blessés* is waiting, and peering into the windows one sees them lying full length on the seats, in the gangways, and the corridors. They stir restlessly in their sleep, and now and again one groans. By the fire the group is thinning. The few wounded have been assigned to the dozens of eager claimants, and already the ambulances are loaded and away. "Il n'y a rien pour vous, monsieur" says the *médecin en chef* with an exaggerated gesture of regret, in reply to my request. Sadly, and a little bitterly, we return home, and as we wait our turn in the line of farm carts at the gate the east is already pearl grey. Chilled by the fresh morning air, I think of the thousands lying there in the cold and mud fifty, sixty miles away, dead and dying. . . . .

G.H.F.G.

List of Works presented by the late Dr. Pye-Smith.

Under the Will of the late Dr. Pye-Smith the following books have been presented to the Hospital and are now available in the Wills Library :—

Quincey, John. Medicina Statica, being the Aphorisms of Sanctorus, 2nd edit., Lond., 1720.
Graaf, Rde. Opera Omnia, Hackiana, 1673.
Cheyne, George. An essay of health and long life. Lond., 1724.
Baglivi, Geo. The Practice of Physick, Lond., 1723.
Cheyne, G. An essay of the true nature and due method of treating the Gout, Lond., 1722.
Willis, Thomæ. Cerebri Anatome, Londoni, 1664.
Swammerdam, Joh. Tractatus physico-anatomico-Medicus de Respiratione usuque pulmonum, Geasbeeck, 1667.
Mead, Richard. Medical Precepts and Cautions, Dublin, 1751.
Verheyen, Philippo. Corporis humani Anatomiæ Amstelodami ac Lipsiæ, 1731.
Cope, Henrico. Demonstratio medico-practica prognosticorum Hippocratis, 1736.
Nunneley, T. Anatomical Tables, interleaved with Dr. Pye-Smith's own notes, Lond., 1838.
Caius, Joh. Britanni de Ephemera Britannica, liber unus, London, 1721.
Huxham, John. An essay on Fevers, 2nd edit., 1750.
Sydenham, Thoma. Observationes Medicæ circa morborum acutorum historiam et curationam, Lond., 1676.
Schuyl, Florentio. Renatus des Cartes de Homine figuris, et latinate donotius, Hackiana, 1664.
Heberden, William. Commentaries on the history and cure of diseases, London, 1803.
Boyle, Robert. Experiments and considerations about the porosity of bodies in two Essays, Lond., 1684.
Turner, Daniel. A Treatise of diseases incident to the Skin, 3rd edit., London, 1726.
Bartholinus, (T.) Anatome, Lugd. Bat., Hackiana, 1673.
Severinus, (M. A.) Zootomia Democritæa, 1645.
Blasii, (Gerardi). Observationes medicæ rariores, Amstelodami, 1677.
Glisson, (Francis). Anatomia hepatis, Hague, 1681.
Nuck, A. Operationes and Experiments chirurgica, Lugd. Bat., 1714.
Pye-Smith, P. H. Syllabus of a course of lectures on Physiology, London, 1885.
Blackmore, (Sir Richard). A treatise of consumptions and other distempers of the lungs, London, 1724.
Kulmo, Jo. Adamo. Tabulæ Anatomicæ, Amstelodami. 1732.
Leeuwenhock, Antonio. Anatomia seu-interiora Rerum, Lugd. Bat., 1687.
Burton, John. An essay towards a complete new system of midwifery, London, 1751.
Dolæi, Johannes. Encyclopædia Medica Dogmatica, Francofurti, 1691.
Culpepper, (N.) Pharmacopœia Londinensis or, the London Dispensatory, London, 1683.
Gibson, (Tho.) The anatomy of humane bodies epitomized, London, 1697.
The Works of Dr. Archibald Pitcairn, London, 1715.
Hermann, L. Grundriss der Physiologie des Menschen, Berlin, 1872.
Peyer, Joh. C. Merycologia, Basileæ, 1685.
Blasius, Gerardus. Anatome Animalium, Amstelodami, 1681.
Regius, Henrici. Ultrajectini fundamenta physicas, Amstelodami, 1646.
Blackmore, Sir Richard. Discourses on the Gout, a Rheumatism and the King's Evil, London, 1726.
The Appendix to Dr. Drake's Anthropologia Nova, or New System of Anatomy, with 51 Copper plates, London, 1728.
Vesalius, Andreæ. Epitome Anatomica, Amstelreodam, 1633.
Peyer, Joh. C. Exercitatio Anatomico-medica de Glandulis Intestinorum, Scafhusæ, 1677.
Nuck, Antonius. Sialographia and Ductuum Aquosorum, Lugd. Bat., 1723.
Hooper, Robert. The Anatomist's Vade Mecum, Lond., 1804.
Havers, Clopton. Osteologia Nova, or some new observations of the Bones, London, 1691.
Cooke, James. Mellificium Chirurgie, or, the Marrow of Chirurgery, &c., 12 Copper plates, Lond., 1718.

Barrough, Philip. The method of Physick, &c., London, 1634.
Hoffmanno, Friderico. Cardianastrophe Admiranda seu Cordis Inversio Memorabilis, Lipsiæ, 1671.
Riverius. Reformatus, sive praxis medica, methodo Riverianæ, edit. novissima, Geneva, 1696.
Blancard, (S.) Lexicon Novum Medicum Graeco-Latinum, Lugd. Bat., 1702.
Haller, (Albert). Opuscula Pathologica, Lausanne. 1768.
Elliot, (John). A complete collection of the works of John Fothergill, with an account of his life and occasional notes, London, 1781.
South, (J. F.) Memorials of the Craft of Surgery in England, London, 1886.
Russell, (Ricardo). De Tabe Glendulari sive de usu aquæ marinæ in morbis glandularum dissertatio, London, 1750.
Heister, D. L. Compendium Anatomicum, 2 tomes in 1, Norimberg, 1732.
Hales, Stephen. Statical Essays, containing hæmastaticks, London, 1733. (Vol. II. only.)

Nursing News.

MATRON'S OFFICE.

On Wednesday, November 4th, Miss Daniels (Sister Ruth), Miss Mc'Ara, Miss Moriarty, Nurses Cosby, Hiles, M. Nelson (Guy's Inst.), Robinson (Guy's Inst.), W. A. Warner (Guy's Inst.), and Quilter (Guy's Inst.) left for Southampton under the auspices of the War Office.

At Queen Mary's Hospital, Southend-on-Sea, are Miss Snelling, Miss Naylor, Miss Purvis, and Miss L. Wood, as well as the Institution Nurses mentioned elsewhere.

GUY'S TRAINED NURSES' INSTITUTION.

Up to date, 38 nurses in connection with the above Institution, either on the Staff or receiving their midwifery training, are engaged in nursing the wounded. The number would be far larger if we included those not actually on the books at the present moment; also those nurses who must for many reasons continue their everyday routine, but otherwise would gladly accept the opportunity for tne devotion of their services to needs so real. There is more of the Guy's motto at this time in "Business as usual" than the scoffer supposes.

Taxi's now leaving St. Thomas's Street carry, beside the familiar uniform, the army gray and scarlet and the long blue coat and felt hat of Red Cross fame, and Larcomb is an adept at handling camp kits. Our nurses write from hospital ships, Boulogne, Dieppe, Versailles, Calais, Biarritz, and Paris.

The journeys by train are described as very long and attended by many discomforts. One letter says: "We have found our holdalls most useful. When travelling they are invaluable to sit upon at the stations, where we usually wait hours, and at night they serve as beds. We are generally six in a carriage, two on either seat and two on the floor, on holdalls, and we manage to sleep! Sometimes we lie across the carriage with our bodies resting (?) on the holdalls. This way, however, is not very satisfactory for the end ones, for when the door opens, as it frequently does, they are apt to fall out."

As the daily and medical papers have reported, the difficulty has been to get the nurses and supplies near to their work, and much tedious delay was experienced. At Dieppe one nurse was, for a short time, amongst an appaling state of things; no adequate medical help or domestic and sanitary arrangements for 80 German wounded with hopeless wounds and tetanus, and out of 18 amputation cases 16 died. She was moved to Claridge's Hotel at Paris under Drs. Garrett Anderson and Murray, and all was in good working order there.

At Biarritz there are many French wounded. A sad account has been given of the over-crowding and horrors at the Casino, now used as a hospital, and another nurse at the Hotel d'Angleterre mentions the usefulness of the hotel as a hospital, but feels she wants more work. Her patients were chiefly from the battle of Mons, and many were convalescent.

Nurse E. Fletcher, who went to Brussels at the beginning of the war, was obliged to return, all the English nurses receiving notice to quit the town at the end of October. Her journey was somewhat lengthy, via Copenhagen, Bergen, Peterhead, and Newcastle.

At Versailles the great stress of surgical work seems over, and among other nursing Sisters, Miss Paterson (Sister Jentie) has been moved to Boulogne, where help is badly required. The enteric wards are occupying the time and energy of the other "Guy's" at Versailles. Off-duty time seems to include a visit to Paris, where are many nursing friends.

A visit to the Palace Hotel, Southend-on-Sea, now Queen Mary's Hospital, was a great pleasure. A happy and vigorous company of our nurses are working under Miss Finnemore as matron. The large, airy, and well-lit rooms are splendidly arranged as wards, with good balconies for convalescents. The patients, Belgian soldiers, now number hundreds. From the number of our staff now nursing in Private House Hospitals it would show that the War Office is availing itself of the many generous offers of accommodation. The nurses are mostly in charge, with voluntary aid assistance.

Nurse L. M. Simpson writes from Clandon Park, Surrey. The staff was appointed from the Red Cross Society. "The house is well fitted up with 100 beds in 14 wards and a theatre. My first night on duty 99 Belgians, nearly all stretcher cases, arrived with horribly septic wounds."

The following is the full list of Institution nurses with their appointments.

For the War Office.—Nurse Canter (at Colchester Military Hospital); and (abroad) Nurses Hills, Hepburne, Mann, Owens, Spedding, Quilter, Nelson, Robinson, F. Davies, Ames, Druce, Dodson, and Warner.

For the Red Cross Society.—Nurses Broome (abroad), A. M. Ward (Netley Hospital), Gwilliam (abroad), L. M. Simpson (Clandon Park), Blyth (Netley Hospital), and Carpenter (Netley Hospital).

At Queen Mary's Hospital, Southend.—Nurses Blott, Latham, Ferdinand, Salter, Sinclair, and Brooks.

For Private House Hospitals.—Nurses Maddison, Horton, Foley, Ford, Richardson, Ellis, Hockin, Sherrard, Sutherland, Pearson, F. L. Smith, and Squire.

Notice.

Examining Board in England by the Royal College of Physicians of London and the Royal College of Surgeons of England.

The following are the dates on which the Examinations will commence for the year 1915:—

FIRST EXAMINATION.

**Chemistry and Physics.*—Tuesdays: January 5; March 23; July 20; September 28.

Biology.—Wednesdays: January 6; March 24; July 21; September 29.

Practical Pharmacy.—Thursdays: January 14; April 8; July 8; October 7.

SECOND EXAMINATION.

Physiology.—Thursdays: January 7; March 25; July 1; September 23.

Anatomy.—Fridays: January 8; March 26; July 2; September 24.

THIRD OR FINAL EXAMINATION.

Medicine (1st Paper).—Tuesdays: January 12; April 6; July 6; October 5.

Medicine (2nd Paper).—Wednesdays: January 13; April 7; July 7; October 6.

Midwifery.—Thursdays: January 14; April 8; July 8; October 7.

Surgery.—Fridays: January 15; April 9; July 9; October 8.

(*Practical Pharmacy*, see First Examination.)

* The Examination in Practical Chemistry will be held on Fridays, January 8, March 26, July 23, October 1.

Candidates intending to present themselves for examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, 8–11 Queen Square, Bloomsbury, London, W.C., *fourteen clear days before the day on which the Examination commences*, transmitting at the same time the required certificates.

All candidates are required to produce certificates of age when entering for the first time for any part of the Final Examination.

All fees must be paid not less than three days prior to the day on which the Examination commences.

Synopses indicating the range of Subjects in the Examinations in Chemistry, Physics, Elementary, Biology, Practical Pharmacy, Physiology, Forensic Medicine, and Public Health may be obtained together with the Regulations.

NOTICE TO UNIVERSITY CANDIDATES.

Candidates are reminded that they should send with the Schedule of Certificates when applying for admission to the Final Examination, a certificate from the Registrar or other official of the University showing that they have passed Examinations in the subjects of the earlier Examinations of the Board.

N.B.—Books of Questions set at the several Examinations of the Board for each year from 1887 to 1914 may be had on application to Messrs. Taylor & Francis, Printers, Red Lion Court, Fleet Street, London, E.C. Price 6d. each, Post-free 6½d.

FREDERICK G. HALLETT.
Secretary.

Reviews, etc.

The Royal Dental Hospital of London.—Annual Reports for 1913. (John Bale, Sons & Danielsson, Ltd.)

This volume of Reports contains eleven original communications, two of the most interesting being one on dental caries from a clinical standpoint, by Mr. J. G. Turner, and one on misplaced mandibular molars, by Mr. W. N. Dolamore. Mr. J. F. Colyer, most prolific of writers, is responsible for an interesting article on periodontal disease.

The volume is well printed and illustrated, but again may exception be taken to the advertsements, which appear to be a feature of these Reports. Shelf-space in these days is limited, and advertisements of the description contained therein seem totally unsuitable for a volume of this description.

Births.

HENDERSON.—On October 23rd, at Alwyns, Amersham, Bucks., the wife of Hal J. Henderson, M.B., B.S. Lond., of a son.

SHIPWAY.—On October 25th, at 61, Queen Anne Street, W., the wife of Francis E. Shipway, M.A., M.D. Cantab., of a daughter.

Marriage.

RYLE—SCULLY.—On October 23rd, John Alfred Ryle, M.B., R.A.M.C.(S.R.), eldest son of Reginald John Ryle, M.D., J.P., of Brighton, to Miriam Power, second daughter of W.C. Scully, C.C., and R.M. of Port Elizabeth.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

"Hold the Fort, mother—your sons are not sleeping."

WITH this magnificent appeal an old Guy's man, now in South Africa, concludes a letter published in this GAZETTE.

R. C. Mullins was an Oxford Rugby Blue who entered the Hospital in 1897, and became House-Surgeon to the late Sir Henry Howse in 1901. He was a distinguished member of the Guy's Rugby Fifteen, and introduced the system of "wheeling" in the scrum. What happy memories the words "Guy's! wheel to the left!!" will recall to men who were here in his time. We ourselves can remember H. R., who was Captain of the Guy's Fifteen in 1909, and House-Surgeon to Sir Arbuthnot Lane in 1910.

This letter fills us with a pleasure so great as to be inexpressible in mere words—an optimistic outlook on the world which gives a feeling of happiness reaching even to the subconscious, and shakes every tissue of the body with the joy of life.

We ourselves will not be imprudent enough to dwell upon the great Imperial Ideal contained in this message. Old Guy's men with a philosophy ripened by experience will do that for themselves. But, even if our own outlook is immature, we may be permitted to put a narrower interpretation on this inspiring message, because the GAZETTE is linked with the past, the present, and the future of our own Alma Mater—fully realizing that the future of this Hospital does not depend in the least degree on our own too facile pen.

At the Annual Garden Party great pains have been taken to point out to us that there are Guy's men in every quarter of the globe—offspring adopted, not at birth, but a time when the true consciousness of self, character, and duty have been evolved from the instincts of childhood, offspring to be trained for the real battle of life and self-help.

It was the late Peter Mills, a former Wills Librarian and an old Army Schoolmaster, who gave some of us the keynote for success in life—*Mental Discipline.*

To quote Samuel Smiles:—"I endeavoured to point out to them that their happiness and well being in after life depended very much upon themselves—upon their diligent self-culture, self-discipline, and self-control; and, above all, upon the honest and upright performance of individual duty, which constitutes the glory of manly character."

Peter Mills encouraged us to read regularly in the library every day, if only for an hour. How few of us reached even this ideal of self-discipline! Mental discipline leads to profitable introspection, to a sense of unworthiness, and to a true appreciation of Duty.

"Whate'er thy race or speech, thou art the same;
Before thy eyes Duty, a constant flame,
Shines always steadfast with unchanging light,
Through dark days and through bright."

The Ode of Life.

"Not once nor twice in our rough island story,
The path of Duty was the way to glory."

Tennyson.

Mental discipline is not confined to the philosopher or student: at Out-Patients, where we may make interesting and useful studies of character, the old soldier walks upright and with a steady tread to consult the surgeon—he is respectful, the word "Sir" comes naturally from his lips, he has learnt the lesson of obedience but not at the expense of dignity or self-respect. For a moment he is the commanding personality in the room and we, on knowledge bent, are humbled by his presence. We sit more upright in admiration and in a chastened mood we realize what in a daily routine we have forgotten, namely, *our own incapacity*. Does our knowledge and experience justify us in becoming old Guy's men? If not, we must remain here!

What is our message to old Guy's men, our elder brothers, scattered through the world? Let it be this:—

> "For still we hope
> That in a world of larger scope,
> What here is faithfully begun
> Will be completed, not undone."
>
> *A. H. Clough.*

Owing to men, whose names were previously on the Admiralty List, having taken other appointments in the meantime and not now being available, and from other similar causes, there are now some vacancies for Probationary Surgeons for active sea-going service. These posts are for unqualified students in their last year of hospital training, and they are principally required for service afloat in destroyers and similar ships.

The Admiralty will make arrangements that such students, if appointed, shall obtain leave, if required, for the purpose of preparing and sitting for their final examinations.

As will be gathered from an article in this issue, written by Mr. Parry-Price, life on a destroyer is full of interest and excitement.

We should also like to point out that it is not advisable for men possessing medical training to offer themselves in any other capacity. Men now enlisted as combatants may make arrangements with the War Office to transfer to medical units if they so desire. The Universities have arranged that time spent in medical duties at the war shall be counted as part of the students' curriculum.

Several pamphlets from the National Anti-Vaccination League have been received this week dealing with the question of anti-typhoid inoculation in the army. Every one is aware that many extravagant claims have been made in the past for serums and vaccines, but we are now beginning to recognise that these remedies cannot replace, but merely supplement, other methods of treatment. If the Medical Profession depended entirely upon statitics for the goodwill and confidence of suffering humanity our position would indeed be a very unfortunate one; happily, it does not. The first virtue of a soldier is obedience, and no good purpose is served, by endeavouring to undermine military authority on the grounds of "conscience," at a time of national peril.

The Dental Society opened their session last week; but what has become of the Physical Society? We sincerely hope that one of the oldest scientific societies in London will make an attempt to hold a few Pathological Evenings, even if it is impossible to complete the usual programme.

We congratulate R. G. Oram and F. W. Paul on their lucky escape from the ill-fated *Rohilla*, also Mr. B. Burnside who pluckily rescued a child from drowning in a canal in France.

Capt. Reynell of the Australian Field Ambulance, and recently H.P. to Dr. Shaw, has undergone an operation for appendicitis in Stephen Ward. We wish him a speedy recovery.

Mr. R. Davies-Colley has joined the Royal Army Medical Corps. He holds the temporary rank of captain, and is now in France. Professor J. T. J. Morrison, senior surgeon to the Queen's Hospital, Birmingham, has arrived at Malta with a British Ambulance party, consisting of 31 medical men and 27 nurses with 12 orderlies, bound for Serbia.

The party has been organised by the Serbian Relief Fund in London, with the assistance of the Order of St. John of Jerusalem.—*Lancet.*

MR. TRETHOWAN'S pupil in the craft of splint-making has left the Hospital to take up a position in the R.A.M.C. at Boulogne.

WE wish to make known the requirements of the Maternity Nursing Home which has been started by the Professional Classes War Relief Council. Mr. J. Pierpoint Morgan has generously lent 13 & 14, Prince's Gate, as the Nursing Home for the period of the war. Many people who are not in a position to give money may be able to give or lend some of the things that go to the furnishing of a house, such as furniture of all sorts, house and table-linen, blankets, cutlery, plate, screens, also bassinettes and baby clothes.

Would those kindly offering help write first to Mrs. Hills, 32, Prince's Gardens, S.W., stating what they are prepared to give and what to lend. On acceptance of their offers they will be asked to send the articles direct to 13, Prince's Gate, S.W., clearly marked in the case of articles on loan. Crockery and glass will only be accepted as a gift as the Council cannot insure against breakage. All furniture will be insured against fire.

MAY we bring to the notice of men who do not live in the College that several sets of rooms are now vacant. In normal times it is a great advantage to live near the Ground at Honor Oak Park, but, at present, as many men as possible should live near the Hospital.

THANKS to the kind co-operation of our readers, the GAZETTE has now reached its maximum size, 24 pages. Owing to the pressure on our columns we are unable to publish some further contributions to the study of picric acid until the next issue.

We should like to call attention to Dr. H. W. Barber's interesting letter on Pneumonia.

Miss Kiddle, late sister "Clinical" contributes an interesting letter to Nursing News.

"I came here to perform my Duty, and I neither do nor can enjoy satisfaction in anything excepting in the performance of my duty to my own country."
WELLINGTON in Portugal.

WE hear with great sorrow that Second Lieutenant L. P. Waghorn was killed in action on November the 6th. Lionel Pengelly Waghorn, aged 21, was educated at Marlborough. He matriculated into London University in June, 1909, and entered Guy's in the following October. He passed the 1st M.B. in July, 1911, and the Second Conjoint Examination in October, 1913,

Second Lieutenant L. P. Waghorn belonged to the Inns of Court Officers' Training Squadron, and on the outbreak of the war, at his fourth year of medical training at Guy's Hospital, he volunteered for service at the front. He was gazetted to the Royal West Kent Regiment, and from there attached to the Royal Berkshire Regiment. He had only joined this regiment a few days when he was killed in action on November 6th. He was the second son of Engineer-Captain W. Waghorn, R.N., formerly formerly Professor of Physics at the Royal Naval College, Greenwich.—*The Times*, November 17th.

A MEDICAL OFFICER'S BRAVERY.

Mrs. Hopkins, mother of the late Lieutenant Hopkins, has received the following letter from an officer of the Devonshire Regiment. Lieutenant Hopkins was Assistant Medical Officer of Health for West Suffolk, and had recently passed his examination for the M.D. of the University of London in State Medicine, being the only successful candidate. He obtained leave from the county council, left his appointment on August 15, and was killed on September 19, his name being mentioned in Sir John French's dispatches :—

We were entrenched on the hills just north of the Aisne at a place called Vailly, and had been under a steady shell fire for a week continuously. Your son behaved with most extraordinary courage and bravery, as our men were being hit every minute, and he did everything in his power to bandage their wounds and relieve their pain, all the time under the heaviest of shrapnel fire.

On September 19 one of the enemy's shells pitched just behind a small trench, completely burying one man and smothering him; your son immediately dashed to the place and did all he could to bring the man round to life, when the unlucky shell came that killed him instantaneously. He was buried that night in a small copse by the river, close to the village, with another of my brother officers.

I may add that during his short stay with us your son became most popular both with the officers and men, as he was always doing what he could for us all, and his death was a great grief to us all. I most sincerely hope that the knowledge that he died in such a really heroic manner may in some way compensate you for your great loss, which I can assure you you share with all the officers and men of my regiment who knew your son.

Reprinted from The Times, Tuesday, November 17th.

A MEETING of the Dental Society will be held on Tuesday, December 1st, at 5.15 p.m., in the Anatomical Theatre, when Mr. Lewin Payne will read a paper on "Fractures of the Jaws." Tea will be served at 4.45 in Class Room No. 2. All members of the Clubs' Union should make a point of attending this reading, as the treatment will be considered both from the point of view of working under suitable and difficult conditions, *i.e.*, at a hospital furnished with the necessary apparatus and appliances, and at temporary hospitals, etc., where such apparatus is unobtainable.

ON Tuesday, December 8th, at 8.10 p.m., in the Nurses' Home, Mrs. Walker (Nurse Kirby, of Guy's), will speak on her work in China. The meeting will be asked to decide whether it is desirable to revive and carry on the Guy's Hospital Missionary Society. Doctors and Students are invited to attend.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—In your correspondence columns repeated comments have been made on the up-keep of the Five's Court.

It appears, from the recent letter on this subject published in your last issue, that the appeals for improvements have not been productive of the response expected by your correspondents. I write, therefore, to suggest that a more direct appeal to those responsible might be made.

Reference to the Clubs' Union Year Book will show that the Five's Court is under the management of the Students' Club, and it seems to me that a General Meeting of that Institution is the right occasion for a discussion of the points which have been raised, At a General Meeting opportunities are given to the members to make suggestions and bring forward schemes for improvements, and the Committee of a Club is only too glad to hear them.—I am, Sir, Yours faithfully,

Guy's Hospital, L. BROMLEY.
November 17th, 1914.

DEAR SIR,—The changes in the nature of Lobar Pneumonia that have taken place during the past few years must have struck everyone who has been in contact with many cases of this disease. As far as my experience in the Medical Wards goes, I should say that it is relatively uncommon now to meet with a pure Pneumococcal infection, which alone conforms with the ordinary text-book descriptions. The occurrence of mixed infections seems to be becoming the rule rather than the exception, and these cases differ very materially in their course, the nature of the temperature chart the physical signs, and their termination.

Resolution seems to be nearly always delayed, and many cases do not come into hospital until the acute stage of the disease is over.

It was originally held that fibroid lung as a result of Lobar Pneumonia was extremely rare, in fact some authorities have doubted its occurrence at all. But these cases of mixed infections are without any doubt followed by subsequent fibrosis in a very appreciable number of instances. Of course I can only speak from hospital experience, and my object in writing this letter is to invite the experiences of consultants and general practitioners with regard to the pneumonias they see in better class practice nowadays.—I am, Sir, yours faithfully,

To the Editor, H. W. BARBER.
Guy's Hospital Gazette.

DEAR SIR: – In the Gazette you ask for all Guy's men serving—so I send you the name—

Surg. Capt. H. R. Mullins,
Imperial Light Horse,
S. African Defence Force.

As a matter of fact he is up with the troops on S. E. border of German South West Africa. I do not know of any other Guyites serving.

If it is of interest to you all, you may add that South Africa is loyal enough, but that owing to traitors we have not been able to send troops to England. Our job out here is no mean one. The country German South West Africa is 1,200 miles long by 500 miles broad! There is practically no water. It has not rained there for three years. In the centre is a fertile area, and in this area is an extremely powerful wireless station which transmits wireless, it is said to Berlin. This is the objective of our troops. They will take ages to get there on account of transport. I mention all this as you may think we have not our troubles. We are loyal enough here and the action of Maritz in turning traitor has cleared the air. Botha is taking supreme command, and many Dutch are going with him. It is only a matter of time here. You may imagine what it means to Englishmen, although Colonists to be so far away, we can only repeat "Hold the Fort Mother, you sons are not sleeping.—Yours truly,

R. C. MULLINS
The Grotto, (Guy's 1897–1900).
Grahamstown,
October 18th, 1914.

Some Notes on Surgery on a Destroyer.

H.M.S. Sheldrake.

On first being appointed surgeon to a destroyer there are several difficulties to be met. There is no sick-bay and there are none of those invaluable people, the sick-bay stewards, men with years of experience behind them. Another great difficulty is the accommodation in a destroyer, I soon came to the conclusion that the wounded in an action ought to be treated practically on the spot, though preferably in a place sheltered from flying splinters, which do so much damage in naval actions. These boats have high foc'sles which form very good shelters for this purpose. As to a sterilizer, I had a tin made, about 8 in. long, 4 in. wide, and 2½ in. high. In this one could boil one's instruments and empty the water out through holes in the lid, then carry the instruments, still sterile in the tin, in one's pocket. This tin is boiled on an electric bottom, made for an electric kettle. If we should be in harbour and the dynamo not running, then the tin can be heated on a methylated spirit stove. I have found this a most efficient sterilizer. I have had a first aid bag made out of an army haversack. This bag has three pouches, in one is an 8 oz. bottle of tincture of iodine, in the next pouch is a solution of strychnine, and in the next is a solution of morphia, there is a red patch over the morphia bottle to render it readily distinct from the strychnine, also the syringe for the strychnine is kept in a pouch beside the bottle, the morphia syringe, as will be described later, is carried pinned to one's coat. In the flap of the bag is a brush for applying the iodine, and a pair of scissors for cutting bandages, clothing, etc.; sterile instruments being separate. In the bag are carried several bandages, several pads of cyanide gauze done up in a bundle in waterproof tissue, also several picric acid dressings which only need to be soaked in water and applied. There is also a roll of cotton wool, and a small bottle of strong carbolic, together with several safety-pins. In a smaller pocket in the front of the bag is a glass tube with sterile sutures already threaded on needles. There are also some extra glass tubules of morphia in solution sealed up. The strength is gr. ⅛ to ℥V. This is also the strength of the morphia in the bottle. The hypodermic syringes supplied by the service can be boiled up, the needle fitted and filled up with morphia, and then carried about. The whole syringe, needle and all, fits into a metal cylinder, previously boiled, which can be pinned on to the lapel of one's coat so as to be always handy during action.

Morphia no doubt will take a great part in this war—it was found during the Russo-Japanese war that the shrieks of the wounded Russian sailors entirely unnerved the rest of the guns crews and prevented them from doing anything like efficient work. Finally the officers had to resort to shooting dead any wounded who made too much noise in order to keep the rest from going all to pieces. It has been found that a dose of quite half a grain is necessary to keep a badly wounded man quiet. One's first duty on attending to a wounded man is to remove all clothing immediately from the vicinity of the wound. The captain of one of our destroyers in the Heligoland action was wounded about the legs in no less than seven different places. There was no surgeon on that ship, but the signalman on the bridge immediately tore his trousers off him and that undoubtedly had a great deal to do with saving his life. The Japs always used to take baths, and put on entirely clean underclothing, and wear no uniform, when going into action, and the results were reflected in the healing of their wounds, however we are not now in the same happy situation in which the Japs then were. They always knew when they were going into action, in the same way as the Germans would know now. We, however, never know from day to day when we shall go into action, so cannot continuously change clothes and take baths. The wounds, especially compound fractures, should be well soaked in iodine, and if there is any doubt about the dressings, they also should be wrung out in iodine. These dressings have proved very successful in the few cases we have yet had. The carbolic carried in the bag is diluted, and a solution of 1 in 20 is kept handy in a basin; if there is any sea at all, this has to be held by someone or else it is all spilt over the deck.

In a destroyer, at any rate—perhaps not so much in larger ships—one finds that antisepsis, and not asepsis, is the only practicable way of dealing with wounds. Asepsis, indeed, would be quite impossible on one of these boats.

I have received some vaccine from Fleet-Surgeon Bassett Smith, of the R.N.C., Greenwich, which can be used both prophylactically and therapeutically. So far I can only speak of its therapeutic value, as I have not had any wounds since it arrived. For prophylaxis the dose is 1 c.c. (or ℥. x.). This contains 25 million streptococci and 500 million staphylococci. The same dose is recommended for cases of operation as well as wounds. For therapeutic use the dose is diluted tenfold, and a dose of 0·5 c.c. is injected every second day. I tried this on a man in a chronic state of furunculosis, and at the end of ten days it had really worked marvels. It was about the first time I had really made an impression upon the ship's crew! So many had hailed my arrival on the ship by coming up and complaining of abdominal pain, etc., but in each case investigation showed that the sufferer was only trying to find a way out of doing his punishment drills, so all he got was Ol. Ric. ʒi., and another dose if that didn't effect a cure. It had a most marvellous effect! Though it was hardly the treatment they had expected.

I have had one or two really serious cases that have given me some anxious moments. One day we had gone right out to sea to the aid of a certain ship, and had helped to take off some of her crew. One of these was a man who had been in her sick bay for four days suffering from gastric ulcer, and kept on ice to suck, and

water to sip. He, with several others, was put on this ship, and we had to toss about in a heavy sea all day. The only accommodation we could give the poor man was a hammock, and very soon he began to get horribly sea-sick, as, indeed, did all the rest that we had taken off. The violent rolling and plunging of a destroyer is rather upsetting in any case after the steadier motion of a larger ship. The vomiting after an hour became continuous, and very soon turned to hæmatemesis. His pulse became weak and rapid, and it was plain that unless something was done, and that rapidly, he would soon collapse altogether. I thought it was a case of do or die, so I gave him an injection of gr. ½ of morphia, at the same time trying to make him as comfortable as possible with a hot-water bottle, etc. This had the desired effect, he fell into a deep slumber, which lasted till we got into harbour, and were able to transfer him to the sick-bay of one of our battleships. I have since heard that he is now doing well. I suppose the dose was rather heroic, but it was, indeed, no time for half measures.

I read in the GAZETTE of October 24th, Mr. Turner's suggestion of trying picric acid in the place of iodine for disinfecting wounds. I had a case of a badly lacerated hand caused by the propellers of a torpedo. The man's hand was very dirty and grimy, and after cleaning it up with methylated spirit I applied picric acid, and drew some parts together with sutures. This was a deep and extensive wound, yet it all healed up beautifully by first intention. The whole business had been carried out in the open on the upper-deck of a destroyer. I have had several cases of burns, though all have been of the superficial order, and I have found healing greatly hastened if, after two days of treatment with picric acid, they are then put on boracic fomentations. I got rather badly had the other day. The coxswain, who used to have charge of all the first aid on this ship, and who now is my sort of assistant, came and told me that one of the men, who often had rheumatism, complained that his pains were so bad that he could not carry on with his work. We were in harbour at the time, so I just told him to send him over to the sick-bay in our depôt ship—a man with rheumatism has no place on a destroyer—I did not trouble to see him, I just told him to go over in the boat, and sent a note with him. That evening I received a note from the Fleet-surgeon thanking me for the case of gonorrhora I had sent!! I might add that the last time that man got ashore was at Dundee, six weeks ago. I think this is really the only "brick" I have dropped so far.

One does not generally see much in the way of results of one's cases, as we always get rid of them immediately on arrival into harbour; however, one can usually enquire after their progress on the next occasion one visits that ship with another case. There is plenty of work to be done on a destroyer, and undoubtedly one's very modest efforts, commenced at the time the wound is inflicted, have a decidedly favourable effect upon the subsequent progress of the case.

Naval actions, so far, have been few and far between, but destroyers have been used for going to the aid of other disabled ships and rescuing their crews, also for bringing back wounded after an action, since they can move so rapidly, and drawing so little water are not so liable to attacks from . . . —(*Excision by Censor*)—submarines. Despite all the hardships, I can imagine few things more enjoyable than this life. Of course we toss and roll about just like a cork, and are often more under the sea than on it. Sometimes we run completely out of fresh food, and have to exist on tinned beef, ship's biscuits for bread, and dripping for butter. There are times when one would be glad of a meal in Café Farnan again! We can usually get hold of supplies of fresh fish, however, all . . . . (*Excision by Censor*).

The average trawler skipper is a cheery old sort, and most generous with his fish. The only newspapers we get the chance of seeing are always three days late, but none the less welcome. Once or twice we have got ashore on some of the wilder Islands, and taking oars as goal posts, and string as a cross-bar, we take on one of the other boats of the flotilla at a strenuous game of rugger, much to the astonishment of any passing natives. As to our more serious doings, well, we have had several exciting moments, then dull times of patrolling, looking for things under the sea, on the sea, and in the air. But of all these doings little may be said at present, there is a censor who has already returned two of my post-cards to me!!

H.M.S. *Sheldrake*, H. PARRY PRICE.
November 10th, 1914.

Papers by Guy's Men.

H. L. Eason, M.S.: Piece of steel in the vitreous.—*Proc. Roy. Soc. Med., Ophth. Sect.*, July, 1914.

R. Affleck Greeves, F.R.C.S.: Supernumerary punctum, lachrymale and canaliculus.—*Ibid.*

E. E. Henderson, F.R.C.S.: Crater-like hole on the disc.—*Ibid.*

—— Rupture of the optic nerve at the lamina cribrosa.—*Ibid.*

John D. Malcolm, F.R.C.S. Edin.: Fibromyoma uteri complicating a columnar-celled carcinoma of the cervix.—*Ibid.. Obstet. and Gyn. Sect.*, July, 1914.

Frank T. Paul, F.R.C.S.: Breast tumours.—*Ibid., Surg. Sect.*, July, 1914.

J. M. Fortescue-Brickdale, M.A., M.D.: Therapeutic notes.—*Bristol Med.-Chir. Journ.*, Sept., 1914.

E. H. Starling and others: The regulation of the heart-beat.—*Journ. of Physiology*, Oct. 23, 1914.

R. H. Jocelyn Swan, M.S. Lond., F.R.C.S. Eng., and others: The occurrence of acute emphysematous gangrene (malignant œdema) in wounds received in the war.—*Brit. Med. Journ.*, Nov. 14, 1914.

T. D. Lister, M.D., B.S.: Artificial Pneumothorax.—*Clin. Journ.*, Oct. 21, 1914.

—— Apparatus for Artificial Pneumothorax.—*Lancet*, Oct. 3, 1914.

Experiences of a "Civil Surgeon."

I HAVE been stimulated by Mr. T. B. Heaton's account of his experiences to try to add to the information he has given with regard to the duties likely to accrue to anyone appointed as "civil surgeon."

The camp here is that of the 22nd Division (part of Kitchener's third army), and the division is divided into three brigades, each consisting of five regiments of about 1,200 men each. Nominally there is a medical officer to each regiment; the five medical officers for each brigade have tents together near the field hospital tent, and generally work together.

At present the work consists of (i.) discharging unfit men, (ii.) casualty and sick parade duties, (iii.) anti-typhoid inoculations, (iv.) general inspection of camp latrines, kitchens, etc. There were a large number of obviously unfit men passed—some wholly edentulous, some with latent cardiac lesions, some deaf, and others almost blind—and these required examining and discharging. Casualty work and sick parades resemble out-patient work at any large hospital too closely to be pleasant. In addition, the sick parade is at 6.45, and the drugs very limited indeed, so that it will be seen thaf this part of the work is not exhilarating. Anti-typhoid inoculations, too, become monotonous.

With two men at work with two 5 c.c. syringes, we can inoculate about 300 per hour. An orderly paints the arms with iodine, the injection is made, and another orderly paints the arm again. The syringe is sterilized by boiling at the commencement, and the needle between each injection by dipping in boiling olive oil; ½ c.c. is used for the first injection and 1 c.c. for the second, which is given in ten days' time. We have not had a single serious complication out of about 5,000 injections already given.

At present we have no ambulance work, but I understand that a stretcher section will have to be organized for each regiment later, when they have mastered the routine drill.

Three of the medical officers here have been sent abroad, and we hear they are at a base hospital at Havre, but it seems likely that we shall be sent with our regiments. At present we are under canvas, but hope to be in huts shortly. Altogether it will be gathered that the work might be more exciting, and I fancy that Mr. Heaton's ambulance work would be a pleasant change: but one feels that it all helps towards the efficiency of the troops here, and it is pleasant to watch their gradually increasing smartness.

If these short notes have served to give an idea of what may be required of a "civil surgeon." they will have served their purpose. Even when enlisted all cannot be sent off to the front as one wishes; some must help with the drudgery of working towards the efficiency of the new recruits, just as much as some men must remain at hospital.

Seaford. W. T. CHANING PEARCE.

The Dental Society.

A successful and well-attended meeting marked the opening of the new session of the Dental Society. The new president, Mr. F. Bocquet Bull, occupied the chair, and the large number of students present both testified to his popularity and augured well for the success of the society during the coming session.

After the minutes of the annual general meeting and an extraordinary general meeting had been read and confirmed, Mr. Bull delivered his inaugural address as follows:—

PRESIDENTIAL ADDRESS.

GENTLEMEN,—In delivering to you my Presidential Address the first thing that I wish to do is to thank you most heartily for the honour you have accorded to me in electing me your President, and to tell you how deeply I feel that honour. It is a coincidence that the first Secretary of the Dental Society to become a President was Mr. J. E. Spiller, a past Staff-Demonstrator. He held the office of President in 1908–9. The second Secretary to become President is myself, I having held the position of Secretary in the year that Mr. Spiller was President. I had little idea then that six years later I should occupy his chair, and certainly no idea that six years later would be a period fraught with such tremendous issue to the whole world. At the start of the war it was a moot point as to whether the Society would hold any meetings, but I am glad that it has seen fit to carry them on, thus living up to the somewhat hackneyed motto of "Business as Usual."

It will not, however, be quite "as usual" as it has been in the past. Firstly, the day and hour of meeting that has stood for at least ten years has had to be altered, owing to the change in time of your lectures, and secondly, and more important, the attendance will be smaller, and we shall miss many well-known faces that under other and happier circumstances we should have seen present. But neither of these circumstances will cause us to show regret, on the contrary, however, it must make us all proud to feel that the Members of our School and Society have so readily volunteered to the aid of their Empire in this its hour of greatest need.

Perhaps, if I may be allowed to say so, I am fortunate in having a subject of such interest as the war for a Presidential address, for I believe most Presidents are usually in difficulty in regard to this matter. Of your fellow members who have volunteered for service most have enlisted as combatants, but I may say here that probably before long we shall have the gratification of seeing some start for the seat of war in a capacity where use may be made of the knowledge that they have gained here. More on this subject I am not permitted to say. At such a time as this perhaps it is not out of place to give to you a short record of all that the School has done in connection with the war. On July 1st of this year, the members of the School numbered 132 students and 55 pupils. At the present time, not including the new

y, the numbers are respectively 88 students and 41 pupils. Thus, apart from three House-Surgeons, 44 students and 14 pupils are aiding their empire—a very good percentage. As well as students and pupils there are the members of our staff, and of these, Lt.-Col. Dowsett is at present stationed at St. Albans, and Lieut. Fry is at Havre, he having gone to France with the first Expeditionary Force. Another would have gone, viz., Mr. Pritchard, but here fate has been unkind. Some of you may possibly remember that in the middle of August great preparations were made for the despatch of a Dental unit of three to Wimereux, to aid one of our Consulting Dental Surgeons, Mr. Newland-Pedley, in dental and surgical work out there. After lengthy dealings with the Privy Council and the French Embassy the unit consisting of Messrs. Pritchard, Millett, and Lowein was ready to start, but on the morning of its departure a telegram was received from Mr. Newland-Pedley stopping it, the somewhat rapid advance of the German forces making it inadvisable to go. After this bitter disappointment to the three concerned, Mr. Pritchard joined the R.A.M.C., and was about to start for Aldershot when he was warded for a hernia.

Mr. Newland-Pedley is now at Rouen working on soldiers sitting in an arm-chair, while he uses for a stool an old packing case. I had hoped to have read to you extracts from a letter received from him yesterday by Sir Cooper Perry, but this I must leave over until the next meeting. Many old members have also joined in one capacity or another, but to one, I think, we may well offer our congratulations, viz., Mr. F. W. Paul—a student here four or five years ago—who was on the ill-fated Hospital Ship *Rohilla* as a dental surgeon. His name appeared in the second list of survivors issued by the Admiralty.

Many of you have formed yourselves into an O.T.C., and perhaps before our session is ended you may also have departed. Indeed it would not be very strange if we find it advisable to hold the last meeting of our session on the Continent, myself sitting on a discarded "52 centimetre," and one of you delivering a weightily-expressed address on the effect of bully-beef and hard biscuits on the human tooth.

However, gentlemen, you have my earnest wishes that the session now starting may be as successful as in the past, and that it may end—however vain the hope—under happier circumstances than it has begun.

The President then announced that the prize for the best paper read during the last session had been divided between Messrs. Clewer and Barnes.

Before calling for casual communications, Mr. Bul raised the question as to the time of future meetings and it was unanimously decided in favour of their being held on the first Tuesday in each month instead of Monday as previously arranged.

Some interesting casual communications were presented by Messrs. Wright, Clewer, Viljoen, Deeks and Deverall.

Mr. Pilbeam then read his paper on "Analgesia." The subject of pain-saving is, of course, one of extreme interest and importance to the dental surgeon, and Mr. Pilbeam dealt with his branch of the subject in a thorough and practical manner, explaining in detail the theory and, by means of the actual apparatus, its practical application.

The writer's regret that the subject under discussion and that of radiography had not the attention they deserved in the curriculum of the dental student elicited the information from Mr. Bull that both subjects were under consideration.

The discussion which followed the paper was of necessity limited to one or two speakers, as the majority present had had little or no opportunity of familiarising themselves with analgesia from practical experience.

However, the younger members, though inexperienced in the subject under discussion, showed a vast knowledge of other but irrelevant subjects which, though provoking much amusement, did not increase our knowledge of "Analgesia."

A Field Aseptic.

To a French doctor we owe a discovery which is likely to have the most beneficial effect in abating the serious developments that often follow comparatively slight wounds sustained in the field of battle. The danger to the soldier who is hit is almost less from the bullet than from the dirt that gets into the wound made by the bullet. Contamination comes from contact with the ground or from the skin of the wounded man, and it is often hours before a proper aseptic dressing can be applied. Against this infection, iodine is a perfect prophylactic if applied at once; and a French doctor has devised a means of making this immediate application possible. To each French soldier is being given a little glass tube, hermetically sealed, containing a prescribed quantity of iodine and a brush. By breaking the tube at a designated place, between the finger and thumb, the brush is found ready for use, and unless the soldier is insensible or quite disabled, he can paint his wound and the skin round it where he lies. The immense difference that may be made in the hospital returns and in the sufferings of the wounded by this simple expedient is not easy to exaggerate. Let us hope our own soldiers will be given the same protection as the French.—*Reprinted from the Globe Nov. 17th 1914.*

Change of Address.

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Glycosuria and Diabetes.

CLINICAL LECTURE No. 2, BY W. HALE WHITE.

Hyperglycæmia must be due to either (1) a diminished destruction by the tissues of the sugar in the blood, or (2) an increased pouring of sugar into the blood. Experiments on animals, although often difficult to interpret, are considered by many to show that when a dog has hyperglycæmia as a result of excision of the pancreas, this is due to a failure of the tissues to utilise sugar owing to the absence of a pancreatic hormone, which acts as an amboceptor. Others believe that hyperglycæmia is not due to a failure of the tissues to utilise sugar, but to an over-production, and it is probable that this is the cause of hyperglycæmia in most cases of human glycosuria. The ease with which in man mild examples can be controlled by diminishing the carbohydrate intake, the fact that we know that in severe cases some of the sugar in the urine comes from the protein tissues, and the fact that although the muscles are the chief users of sugar, yet diseases such as progressive muscular atrophy, muscular dystrophy, anorexia nervosa, and cancer, in which the muscular wasting is so extreme that it is difficult to imagine that the muscles are not failing to use their usual food, are not accompanied by glycosuria, all point to this conclusion. Further, if we believe that hyperglycæmia is due to impaired utilization of sugar by the tissues, then when on the later progress of a severe case of diabetes the sugar in the blood is derived from proteins and fats of the tissues, we have the extraordinary state of affairs that the presence of excess of sugar in the blood as a result of the failure of tissues to utilize it is followed by still more in the blood from the proteins and fats. We should have expected that if the body was deficient in energy because the sugar in the blood was not burnt up, that was the very reason why other metabolic processes should be carried out as completely as possible.

The varying incidence of diabetes in different races, its extreme gravity in the young, the many possible causes of glycosuria, the way in which different diabetic patients can utilize different sugars all point to considerable variations in the behaviour of the body to carbohydrates. This is also seen experimentally, for if small amounts of lævulose are given to a dog whose pancreas has been so far destroyed that the animal cannot utilize any dextrose given by the mouth, only a little dextrose is excreted in the urine, and the greater part of the lævulose is utilized. This fact is sometimes of use in treatment, for as cane sugar is in the body converted into dextrose and lævulose, a diabetic may sometimes get energy out of cane sugar when he could not out of dextrose.

Acidosis.—The perverted metabolism of proteins and fats which in a severe case of diabetes is the cause of a great part of the glycosuria, results in the circulation in the blood of oxybutyric acid, diacetic acid, and other acetone bodies derived principally from fats; they are excreted in the urine, and diacetic acid is easily recognised there by the ferric chloride reaction. Generally speaking, the constant presence of this reaction in a strong degree indicates a serious outlook. Oxybutyric acid and diacetic acid are met with in the urine in many conditions, *e.g.*, starvation, severe vomiting, and after anæsthetics, and when they are present the patients often have dyspnœa without lividity, indistinguishable from the dyspnœa often seen in severe diabetes. It is believed that this is due in both cases to the stimulation of the respiratory centre by the increased acidity of the blood, just as it is normally stimulated by CO_2 and by lactic acid after severe exercise. Further, the dyspnœa of heart or renal disease, when there is no lividity and the dyspnœa of high altitudes are believed also to be due to an increased acidity of the blood. All these forms of dyspnœa are therefore due to acidosis. Recently it has been shown by several observers that in diabetic coma, in which this form of dyspnœa is very striking, the alveolar air contains much less CO_2 than normal. Dr. E. P. Poulton has shown by many observations that this diminution of CO_2 in the alveolar air precedes the onset of coma, and may be used to foretell it. He has devised a simple apparatus by which the alveolar CO_2 can be easily estimated. This is, therefore, an additional means of clinically telling when coma is imminent. The suggested explanation is that the increased acidity of the blood excites the respiratory centre to great activity, and in consequence of this increased pulmonary ventilation the CO_2 is got rid of rapidly, An observation only takes about ten minutes. The values for CO_2 in normal individuals is between 5 and 6 per cent. The same values are obtained in mild diabetes, and values of 4 per cent. or over show that the patient is free for the time being from liability to coma. Values under 4 per cent. indicate that coma

will come on in forty-eight hours, and under 2 per cent. within twenty-four hours. The figures during actual coma were sometimes as low as 0·8 to 1·5 per cent. We must allow that the abnormal acids of the blood cause the dyspnœa of diabetics, but whether they produce the fatal coma itself is doubtful. Coma is far commoner in diabetes than in other varieties of acidosis. Giving enormous quantities of alkalies quite fails to save most cases of diabetic coma. Oxybutyric acid itself is not a coma-producing poison, and coma is not seen in scurvy, in which the alkalinity of the blood is much diminished. All we can say is, that the cause of diabetic coma is unknown, but it is bound up with a condition of acidosis. We should never forget it is liable to be produced by suddenly withdrawing carbohydrates from the food.

Treatment.—The influence of the nervous system is well exemplified in the benefit that follows a tranquil life. Unless the case is severe, a moderate amount of work without any anxieties, excitements or worries suits best. The bad effect of excitement is seen not only in its effect on the sugar, but it is well known that it will induce coma. A long journey to see a celebrated physician brought on coma fatal in the doctor's house. Although some mental and muscular work are desirable in order to maintain the general health, yet both must stop short of fatigue, for the patient is losing much energy in the unoxidized sugar passed in the urine. It is clear that early hours and a country life, with plenty of fresh air, are better than a town life.

The mildest cases are those in which the patient is over 60, passes a little dextrose in his urine, and has nothing else the matter with him. Such a person who usually over-eats is probably only an example of the fact that while in the young sugar tolerance is high—as seen in the large amount of carbohydrate in comparison to their weight that children eat—in elderly people it often falls, although there are many adults who have an excessive craving for carbohydrates almost as strong as that which some have for alcohol. Usually this mild glycosuria is easily controlled by diminishing the carbohydrate in the food, and if they can go such people derive much benefit from visiting one of the health resorts or sanatoria which lay themselves out to diet on diabetics.

If the illness is more advanced than in the slight case we have just considered, the total daily output of sugar on ordinary diet must first be ascertained. Then the carbohydrate in the food should be slowly diminished and unless the case is severe we shall reach a point at which no sugar appears in the urine, often this is not attained until all or almost all carbohydrates have been taken out of the diet. Patients frequently fail to take enough fats and proteins to make up for the loss of carbohydrates. Fats such as butter, bacon, fat ham, cream, and olive oil should be taken if they can be digested, for they have double the energy yield of proteins. The loss of bread is usually so keenly felt that proteins are taken in the form of diabetic breads and biscuits. We must remember that all these contain some carbohydrates, but none with over 5 per cent. should be used. Every medical man should occasionally analyse any diabetic food he employs, for many preparations are sold which contain mischievous amounts of starch. None of these diabetic breads or biscuits are really nice, but usually one may be found which the patient can take, especially if he uses plenty of butter, or he may take some of the sugar-free jams sweetened with saccharine which are on the market. If it is desired not to allow any milk because of the lactose in it, one of the sugar-free milks which are sold may be given or the patient may take washed cream mixed with albumen water made from white of egg. Alcohol being a food which entails no digestion may be allowed, but of course not in a form which contains sugar. When the patient has reached a diet on which no sugar has been passed, or on which the diminished excretion of sugar is constant he should be kept on it for two or three weeks according the severity of the case. The most important advance in the treatment of diabetes is the discovery that some patients can tolerate some varieties of carbohydrates better than others, and our endeavour must always be to find what variety of carbohydrate each patient can best take, that is to say of which variety can most be taken without leading to an increased output of sugar in the urine or, if all lead to an increase, which leads to least, for often the increase of the urinary sugar is so slight that the gain of energy to the patient by the sugar in the diet must be considerable. Lævulose often causes little or no increase of sugar in the urine, and I frequently use it for feeling my way back to some carbohydrate in a diabetic. Sometimes I have given cooked dahlia tubers, for their starch—inulin—is converted into lævulose. Soya beans, too, ground into flour, may be tried, for they contain less carbohydrate and more fat than almost any vegetables. Some patients can take fair quantities of skim milk without increasing glycosuria

(hence the milk cure), others can oatmeal (hence the oatmeal cure), others potatoes (hence the potato cure). A recent account of these and other carbohydrate cures was given by Prof. Rosenfeld before the International Medical Congress held last year, and he pointed out that one of the most useful carbohydrates to give is hediosite a C_7 sugar, some patients can apparently not only utilize it, but the taking of it leads to a diminution of the glycosuria. If the case is not severe it is often of benefit to give one or two days of complete starvation, this leads to a disappearance of the sugar which may not return in as large amount as before when ordinary carbohydrates are given. There are many patients who are benefited by going to some place which has alkaline springs, and some recent work goes to show that alkalies are of benefit in diabetics, a point of great interest to me for I am accustomed whenever a diabetic is ever so little drowsy to give large doses of bicarbonate of soda with a view of trying to ward off impending coma, and I certainly think that some of these patients are improved considerably in all respects by the alkali.

In severe cases we often find it impossible by reducing the carbohydrate in the food to cause the complete disappearance of sugar from the urine, for some of it is derived from proteins and some from fats. Then it is best, after slowly reducing his carbohydrate, to keep the patient for a time on such a diet that further diminution of the carbohydrate in the food does not lead to further lessening of the glycosuria. If this is done for some weeks it will often be found that the patient can then take, without increasing his glycosuria, additional carbohydrate, as, for example, oatmeal, which we have seen diabetics may bear well; if so, this will all be to his advantage. Such a case demands an estimation of the nitrogen excretion and a knowledge of the nitrogenous intake—indeed, as a matter of interest this is desirable for most cases except the mildest—as part of the sugar comes from protein both of the tissues and the food. The amount of sugar that may be derived from protein is obtained by multiplying the number of grammes of nitrogen in the urine by according to some the figure 5, according to others 3·5. It is useful, in order to watch the progress of the case, to divide the grammes of sugar in each twenty-four hours' urine by the grammes of carbohydrate in food plus possible grammes of sugar from protein. To avoid fractions it is customary to multiply by one hundred. The result, called the coefficient of the excretion of dextrose, gives an indication of the progress of the case. The lower it is the better for the patient.

If the presence of a large amount of diacetic acid, or any other reason, makes us apprehensive of coma, we must go very carefully in the reduction of carbohydrates, for reduction, especially if extreme or sudden, is very prone to lead to coma: indeed, as is well known, coma is often heralded by a spontaneous drop in the sugar in the urine, and then giving the patient sugar does not bring him out of the coma. In a severe case it is bad treatment to try and get rid entirely of the sugar from the urine. In milder cases the patient may sometimes be cut entirely off food for from one to three days for a time (Guelpa treatment), being allowed, however, water and tea to drink; this, as already mentioned, often facilitates considerably the disappearance of sugar from the urine. Hence, in some "cures" the patients have starvation days from time to time, but, of course, we must be acutely on the alert for signs of acidosis, and it is the danger of this that renders necessary the greatest caution in allowing starvation days.

It is clear that to treat properly cases of glycosuria which are not mild, attention must be paid to many details. The whole twenty-four hours' urine must frequently be saved, the sugar and nitrogen in it quantitatively estimated accurately, the carbohydrates and proteins allowed must be weighed, experiments must be made to see which variety of carbohydrate the patient can deal with best. It is well, also, to know the caloric value of his daily diet, and the patient should be carefully weighed every week. All this is very difficult to carry out in the patient's own private house. Some patients are so ill that they ought to go into a hospital or nursing home, where these observations can be made, but a great many are not sufficiently ill for this, nor is it desirable, for they should be up, and ought to be a good deal in the open air taking exercise. For them some place in the country at which the urinary analyses and experiments with different foods could be properly made is highly desirable. The doctor should have associated with him a skilled analyst, and should be specially interested in, and competent to deal with, dietetic problems. A patient would stay at such a place until it has been found which diet most satisfactorily controls his glycosuria, for again it is worth while to remind you that different diabetic patients deal differently with the various varieties of carbohydrates, and in many instances carbohydrates should not be

entirely withheld. When the diet had been found which suited the patient best, then he could return to his home and his medical attendant with detailed instructions as to how he should live. The mild cases in elderly people which are unaccompanied by any oxybutyric acid and in which the little sugar that is passed is easily controlled by diet, need hardly go to an institution, they can be treated at home. As might be suspected, the patient with a comfortable income and ample leisure does best. Young patients with severe diabetes should stay at home. The journey to a health resort often induces coma. The treatment of poor patients suffering from diabetes is very unsatisfactory, for although we may do them much good in the hospital, yet when they get outside it is almost impossible for them to afford diabetic foods, and many of them would not eat them even if they were provided for them. When these poor people are away from the controlling influence of a medical man they sooner or later take unsuitable food, and they cannot lead the quiet and easy life that is so necessary.

I have not said anything about drugs in the treatment of glycosuria, for they are of little importance in comparison with diet; patients vary much in the readiness with which they respond to drugs, and it is impossible to tell beforehand whether or not drugs will benefit. But opium and codeia certainly sometimes help to reduce the sugar in the urine, nor, as far as I know, does either ever become a habit with a diabetic, and although there is a strong tendency to become comatose, yet I have never seen opium poisoning in a patient with diabetes. Aspirin is reported to diminish glycosuria occasionally.

If a patient is in coma it is very rarely that we can save him, but as in such a condition the blood contains much oxybutyric acid, the attempt may be made to neutralise this by giving plenty of bicarbonate of soda. I usually give it in milk, for it is undesirable that these patients should not take any carbohydrate—in a bad case 80–100 grains may be added to each pint, and the patient may drink three pints a day. Generally polyuria is present, and so fluid is absorbed fast from the alimentary canal; therefore it is usually unnecessary to inject alkalies directly into a vein. If put under the skin they may cause sloughing; if for any reason they cannot be given by the mouth, they may be given by the rectum. When, however, the patient is merely liable to occasional drowsiness or coma seems likely either from the ease with which a ferric chloride reaction appears, or from the presence of sickness and abdominal pain, or because the case is very severe, or because the alveolar CO_2 is a little low, then much may be done to avert it by keeping the patient quiet both bodily and mentally, and by giving milk containing plenty of bicarbonate of soda. I have known patients who seemed liable to coma improve very much on such treatment and get well enough to leave the hospital. As excitement predisposes to coma, sodium bicarbonate is often desirable on admission to hospital or before an operation. Pyrexia may lead to an increase or to a diminution of the sugar. During an influenza epidemic a lady, not known to have diabetes, had fever, which was rightly thought to be due to influenza. After four days she became drowsy. The urine was tested; it contained no sugar, and so diabetic coma was excluded. The urine was not then tested with ferric chloride. The next morning she was comatose. The urine gave an abundant ferric chloride reaction, a minute trace of sugar was found in it, and the breath smelt of acetone. Here no doubt the pyrexia contributed to the disappearance of the sugar, but forgetfulness of the fact that absence of sugar may indicate the oncoming of coma prevented the testing for diacetic acid on the first occasion, and hence the correct diagnosis of influenza occurring in a diabetic subject was for a few hours overlooked.

I have already urged the probability that coma is only associated with and not directly due to acidosis, and the extreme improbability of recovery from it. Still, I remember the case of a young woman suffering from diabetes who was pregnant. Towards the end of pregnancy she became comatose. Owing to pelvic deformity Cæsarean section had to be performed, the coma gradually passed away, and although still diabetic she was alive a year after the confinement, and the child was well. She was able to have all the ease and comfort that money could buy.

Prognosis.—The main outlines of the pronosis are well defined, but there are many exceptions. The younger the patient the worse the prognosis; this is nearly always true, but I knew a child of about a year old live a year, and one of five who had phthisis lived considerably over a year. At the other end of the scale we have the elderly man whose sugar is easily controlled by diet; usually he passes no diacetic acid; he nearly always does well. Indeed, it is highly probable that a number of elderly persons, men especially, have a little glycosuria, but they go to their grave without

its ever having been suspected, and, as far as we know, without its ever having done them any harm. Between the extremes of childhood and people who have passed the fifth decade, the younger they are the worse the outlook; it is especially bad if they have wasted rapidly, if they have much diacetic acid, if they are often drowsy, if they have complication—*e.g.*, phthisis,—if they have an extreme degree of lipæmia—as for example when it may be seen in the retinal arteries—or if they must work hard for their living; but in most cases it is impossible to give an opinion until the effect of treatment is seen. I know persons who are alive and in fair health, although they have had diabetes for twenty years, and whose urine always contains some sugar and often a little diacetic acid, but then they have always been very careful to carry out the treatment. The onset of other diseases has a varying effect on diabetes, sometimes making it worse, sometimes, strange to say, checking it. Thus, urticaria, typhoid fever, pneumonia, and surgical operations have all been known to lead to a very great diminution or even absence of sugar in the urine in diabetics.

Some Experiences of Dispatch Riding in Belgium and France.

THE title of motor scout which I was given in the GAZETTE is a misnomer. I went out with the Expeditionary Force, in company with about a hundred others, as a motor-cyclist dispatch rider. To give a clear idea of our duties it is necessary to go in some detail into the methods of communication in use in our army.

The whole business of linking together the various units, and conveying intelligence from one to the other, is entrusted to the Royal Engineers, who supply signal squadrons and signal companies to cavalry and troops of the line respectively. Thus, the body to which I found myself attached was the 9th Signal Company, which is responsible for communications between the headquarters of the 9th Division and its component parts—the three infantry brigades, four artillery brigades, divisional cavalry, cyclist company, field ambulances, and others, and last and most important, with the cavalry brigades acting on its flanks during advance or retreat.

The company was composed of three cable sections, which, whenever divisional headquarters were likely to remain stationary for some hours, ran out lines to the infantry brigades, and sometimes back to Army Corps headquarters, thus securing continuous telegraphic or telephonic connection; and a section composed of half-a-dozen cyclists, including a sergeant, who carried the office—a box containing the signal register and stationery—and eleven of us motor-cyclists. Between us we were responsible for all remaining message work. Always one motor-cyclist had to be at the office, day or night, awake and ready to take a message, calling up the next man as he went. We had some experience of the work at Aldershot before we sailed, and found it hard enough, but it was mere idleness compared to what we were going to go through during the retreat.

For throughout that remarkable journey we hardly ever halted long enough to make it worth while for our men to lay cable, so that it fell to the lot of the other section to maintain the communications of the entire division. Luckily the nights at that time were fine, and the roads dry, but it was a strenuous fortnight; 289 messages delivered in twenty-four hours was our best day's work, and I fancy we none of us averaged more than three to four hours sleep, and that taken in odd scraps, in odder places.

For the first few days after we got out there it was quite impossible to realize that this was war. We trekked over the plains under a blazing sun, and enjoyed the picnic, and the novelty of bully beef and biscuit. Then came August 23rd—we were between Mons and Charleroi—and the first sound of guns, the first sight of blazing villages. Even then it was more like a firework display; they were fighting the French on our right, and we were out of it as yet.

Next day some of us were under shell fire for the first time, and saw men hit, and that was an experience which at once changed the atmosphere in which we moved. It is a very odd feeling, hearing one's first Black Maria setting up its crescendo scream, and ending in an enormous report and a cloud of black smoke, close enough to be unpleasant; and the hole in the ground, though its size has been much exaggerated, is certainly impressive. We were often under fire after that; shrapnel was alarming at first, until one learnt its ways, rifle fire which we seldom met with had no terrors when we did, but the high explosive B. M.'s never quite lost their moral effect. After a while one could gauge the direction within thirty to forty yards at the first scream, and it became a question of distance; a moment of the most intense apprehension, and an inward sigh of relief.

The German gunnery were infernally accurate: during the retreat there was not so much scope for it, but at the Aisne there was hardly any outstanding feature on the map which was not systematically shelled at one time or another.

The roads leading to the Infantry Brigades were so accurately shelled during the day-time that often it was impossible to send up supplies or fetch wounded, and the cables laid by our men were again and again cut by the Black Marias: which meant more work for us and under rather stirring conditions. It was really better to be riding a motor-cycle, for the noise of the engine drowned the heralding scream, and by the time one saw a gaping hole in the way, or a haystack uplifted on a pillar of smoke one realised that one hadn't been hit; *that* shell was over at any rate.

The night work was a great strain. When we turned and began to advance there were many scattered patrols of Uhlans about the roads, and taking messages out to the Cavalry Brigades was an exciting pastime: each body of horsemen was approached with caution until one heard them swear in unmistakable English. It was no easy matter to find the way on occasions: our maps were very good, but as we had no lights we had to commit the route to memory before we started out for our destination and trust blindly to memory and map. The former failed me one dark night and I ran well into the German lines to discover it; was challenged and shot at by a sentry at thirty yards distance and returned a lucky and a wiser man to look up another road.

When the rain came and the roads were rivers of mud, night riding really was a grim business, as motor-cyclists will appreciate. It was a matter of riding feet down on low gear for miles at a time, and nothing amiss if the front wheel bumped into the back of a wagon now and then. And when they began to dry it became a routine to scrape the clay out of the vitals of the machine every five miles or so.

Food was the important thing. As long as we got food we could carry on, with a minimum of sleep, but there were times when we were very hungry. The A.S.C. worked wonders, and the supplies were almost always up every day, but it was the lot of most of us at some time to be out on a message when the rations were given out and the tea was made. The tinned beef is really excellent food and quite appetising, nor did I ever come across any that had spoiled in the keeping, but the desire for fresh food was becoming rather pressing even after a month.

We most of us had some near shaves during the first few days of the Aisne, when our division suffered very heavily. I had my machine struck by shrapnel while I was sitting the other side of the road, and on the same day saw another of our lot emerge unscathed from what seemed to be the exact landing place of a B.M.; another was cut off from his machine by a German counter attack on his way to the trenches, into which he had finally to get, and use a borrowed rifle for the nonce. And on the fourth morning of the battle in that particular corner I stopped a small piece of B.M. in the thigh. I was very lucky to get off so lightly, for several men round there were killed by the same shell.

It was only five weeks from the date of embarkation to the day I was hit, though it seemed a great deal longer; long enough at any rate to sicken anyone of the reality of modern fighting. There are exciting times, and I greatly enjoyed the work, especially as our section of motor-cyclists were mostly from Oxford and Cambridge, all delightful people to be with. I was very sorry to have to leave them.

But I am convinced that no one who has seen war could fail to be impressed by the waste and useless suffering of it all. The romance of battle is very well in the headlines of the evening press, let our journalist after a night in the rain taste war on an empty stomach, and then tell us how he feels!

C. P. S.

Appointments.

Municipal.

Dr. S. R. Alexander has been re-elected Mayor of Faversham.

Colonial Medical Service.

West African Medical Staff: N. A. D. Sharp, M.R.C.S., L.R.C.P., Medical Officer, Gold Coast, has been transferred to Nigeria.

Royal Army Medical Corps.

Capt. F. F. Burghard, M.D., F.R.C.S., to be temporary Colonel.

Capt. F. C. Whitmore, Second Wessex Field Ambulance, to be Major.

J. W. Bird to be Captain, 6th London Field Ambulance.

F. J. Tipper to be Dental Surgeon, Royal Herbert Hospital, Woolwich.

Temporary Lieut. F. S. Brereton, late Capt. R.A.M.C., to be temporary Captain.

To be temporary Lieutenants: J. H. Campain, G. G. Timpson.

Capt. A. S. Liebson, M.O., Rand Light Infantry, "C" Force, Capetown.

Surg. Capt. H. R. Mullins, Imperial Light Horse, South African Defence Force.

Capt. H. M. Clarke, R.A.M.C., Territorials, 3rd Southern General Hospital, Oxford, seconded for service abroad with the 10th French Army Corps as Surgeon and is now serving at the Military Base Hospital, No. 30, Rennes, Brittany.

Attached to other than Medical Units.

G. H. H. Manfield to be Lieutenant.

A. Scott Turner to be Lieutenant (late Lieutenant, 2nd Volunteer Battalion, East Surrey Regiment).

Naval.

Temp. Surg. H. T. Depree to *Vivid*, additional for Plymouth Hospital.

Staff Surg. W. K. Wills, M.B. (R.N.V.R.), to the *Vivid*, additional for Royal Naval Barracks, *vice* Caldwell.

Acting Surg. F. C. Hunôt has been confirmed in the rank of Surgeon in His Majesty's Fleet.

Sir Alfred Fripp has been appointed Temporary Consulting Surgeon to the Royal Navy (H.M. Hospital Ship *Sheelah*).

Casualties.

Capt. H. G. Gibson, R.A.M.C., wounded.

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Letters from Guy's Men Abroad.

Hospital Militaire No. 20,
Lannion,
Cotes du Nord,
France.

From B. BURNSIDE, Medical Officer, Oct. 13th, 1914.

Now we have been here a week I am writing to give you a somewhat concise account of our work. The hospital here is a large school which has been converted into a hospital. We have six wards holding about 50 patients each and a few small wards for tetanus and typhoid cases. In the wards the beds are put up at about 12 inches apart. The nursing staff is comprised of ladies of the district and nuns from the neighbouring convents. They are very good.

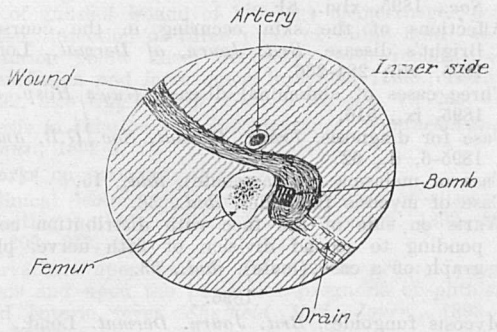
The operating theatre is a room which has been converted into a theatre; all the fittings have been removed and the walls whitewashed and peroxidised, and we have a good operating table. The sterilizer we brought with us does good work. We are glad of the instruments we brought with us, as the ones supplied are those used 30 years ago. Our theatre sister is a nun, and is excellent, being very efficient. The only anæsthetic we have is chloroform; there are only 150 grammes left, and no more can be had anywhere, so we are in rather a hole. For short cases we used "somniforme"; it is ethyl bromide, an anæsthesia which lasts for about three minutes, but it gives rise to great excitement.

During this week we have done 50 operations between us: of these, 4 were amputations, 2 herniæ, and one excision of the eye. The others have been for the removal of bullets, fragments of shells, putting in drains, and opening wounds, etc.

We start work at 9 a.m. and finish at 6 in the evening. Jackson and I have been doing most of the surgery. The night before we arrived 150 wounded came in and 56 two days ago. They are sent down from the front in horse boxes—12 in each. They are put on stretchers, 3 below, 3 above, and 3 on each side. The average length of the journey is about 66 hours, and in most cases they have not had their dressings changed for 4—6 days, and when removed —the wounds stink. Almost all the wounds are infected.

Most of the wounds are caused by shrapnel and bullets, and nearly all we get here are wounded in the legs, a few in the arms and elsewhere. In some cases the missiles (generally bullets) have traversed the limb; the shrapnel lies buried somewhere in the limb. In those cases where the bone has been struck, the fracture caused is awful, the bone being split into many fragments, and as, in nearly all the cases, infection is present, it is difficult to treat them. Our treatment consists of putting a drain in and making a counter incision opposite and syringing daily with hydrogen peroxide. The splints are very bad so that every time the wounds are dressed the fragments are displaced.

The fun is in trying to find bullets—we want an X-ray apparatus badly. To give you some idea of the difficulty, I will describe a case of Jackson's. A bullet entered one inch above the knee on the inner side; there was no exit wound and nothing to guide one where the bullet was. Quite by accident, when holding the foot he felt something just internal to the internal malleolus, and it proved to be the bullet. In many cases it is impossible to locate the bullet until it either forms an abscess or some spot becomes painful. The wounds not involving bones generally do well with drainage. I had rather a good case a few days ago. I was asked to look at a man who was said to have a secondary hæmorrhage from the femoral artery. When I got there a tourniquet had been put on and we took him to the theatre intending to tie the femoral. There was a wound about an inch and a half external to the femoral artery in Scarpa's triangle. I exposed the femoral and took off the tourniquet, but there was no bleeding. The man was rather shaky, so we infused him on the table. On exploring the wound I found it to go inwards under the femoral artery, and in exploring it I opened an abscess, with much blood-stained pus, which, I take it, was a secondary hæmorrhage into the abscess cavity. I found a piece of an aeroplane bomb about 3 inches long, 1 inch wide and half an inch thick. I have tried to draw what was found.



The bomb had passed beneath the femoral artery and then turned downwards; the roof of the wound was formed by the femoral artery. I drained it as shown, and the man is doing excellently. I wish —— was here. I think his hair would turn grey. Very often when we are operating men come in smoking, hats on, ordinary clothes, and spit on the floor. We have some French medical students working here; they operate sometimes.

I am glad to say that all four of our amputations are now well on the way to recovery: two through upper third of the tibia and two through the lower

third of the femur, one for gangrene of foot, one for a very badly smashed foot and ankle, the other two for bad compound fractures of tibia and fibula.

I am afraid most of the bad compound fractures will have to be amputated; they seem to do very badly.

If this is any use for the GAZETTE print it. I am afraid it is rather disjointed, but am writing it from my diary. We are all well and fit. Yours sincerely,

B. BURNSIDE.

Lannion,
October 26th, 1914.

From R. W. P. JACKSON.

DEAR SANER,—I am writing to let you know how we are getting on, and to ask you to do a favour for us. The hospital is fairly empty at present as we have had no wounded in for a fortnight. An inspector was dining with us the other night, and he has decided to put on an extra 400 beds in various buildings, without, apparently, any increase in the medical staff, so we can look out for trouble in the near future. We should be awfully obliged if you could send us two lion-forceps, assorted drills, screw-driver, plate and screw holders, plates and screws for humerus, tibia, and femur. It must sound pretty good cheek for us to talk about plating, but you must do something for the wounded, and nobody else seems keen on taking it on. Of course, they all pus more or less from infection in the cattle trucks, so the "op.'s" will be . . .

We should be pleased if you could send them off as soon as possible, and if you will send the bill to A. E. N. Ward (you met him at the Astley Cooper concert last Christmas), 65, London Wall, E.C., he will pay it.

We are having a very good time, but I have got a lad with the head of his femur shattered by a bullet who is "pussing" like fury in spite of removal of fragments of bone and large incisions in front and behind. I do not see what else I can do short of disarticulation at the hip, so I am keeping him on a long Lister and trusting to frequent dressings. So far we have not had any deaths among the cases under our care, but it has been a very close shave once or twice. I had one lad with a bullet in his lung who developed pleurisy and pneumonia. Pulse uncountable, temperature 104°, respirations 52. He was given the sacrament by a priest and removed to a small room to die in peace. Remembering that it is considered bad form to send a case to Bell with fluid in the chest, I drew off about 600 c.c. of turbid, blood-stained fluid, and for some unknown reason he has decided to get well. Burnside has gained much renown by curing a negro with tetanus. The scheme, I believe, is Doyen's, and consists in giving 60 c.c. of serum into the spinal canal followed at intervals of two days by two injections of 30 c.c. The man was pretty bad and had biten his tongue through. We give nothing but $CHCl_3$. If you should see Mr. Page would you tell him that a copy of his air-way I have got is very much admired by everyone here. Burnside wishes to be remembered to you. Hoping that it is not too much trouble to get the instruments, and thanking you for getting us this job, Yours sincerely,

R. W. P. JACKSON.

Hôpital Militaire, No. 20,
Lannion,
Cotes du Nord,
France,
4th Novembre, 1914.

Am sending you copies of the Orders for the day mentioning the heroic conduct of Burnside, who saved a little boy from being drowned, thinking that it would be of interest to you for insertion in the GAZETTE.

I wonder if you could manage to have a copy of the GAZETTE sent to us as regularly as possible, as we are not having much news. Thanking you in anticipation, believe me, Yours sincerely,

J. E. de ROBILLARD.

P.S.—I also enclose a copy of the Major's letter to Burnside.

Direction du Service de Sauté, No. 148.
Rennes.
le 3 Novembre, 1914.

Le Directeur du Service de Sauté de la 10e Région à Messrs. les Médecins-Chefs de la 10e Région.

ORDRE DE LA 10e REGION, No. 12.

Le Général Commandant la 10e Region est heureux de porter à la connaissance des troupes sous ses ordres l'acte de courage accompli par le Dr. Bruce Burnside, Médecin Anglais attaché à l'hôpital No. 20 dans les circumstances suivantes :—

"Le promenant apres déjeuner sur le quai de Lannion, s'est jeté à l'eau, profonde à cette endroit de plus de deux métres, pour sauver un enfant tombé dans la rivière. Après avoir ramené l'enfant à la vie s'est bien dérobé à toutes les felicitations que son acte a été connu du Medecin Chef que par une indescrétion."

Rennes, le 3 Novembre, 1914.

Le Général Commandant la 10e Region,
(Signé) MARION.

Cour amplification.

Le Chef de l'Etat Major,
(Signé) DELAMARRE.

En transmettant cet ordre de la 10e Région à Monsieur le Dr. Bruce Burnside, le Directeur du Service de Sauté a l'honneur de lui adresser ses félicitations personnelles.

(Signé) ANDRIEUX.

Hôpital Complementaire, No. 20,
Lannion,
4th Novembre, 1914.

Le Médecin Chef de Service à l'hôpital No. 20 â Lannion à Monsieur le Docteur Bruce Burnside.

Mon cher camarade,—Je vous remets l'origine de l'ordre du Général Commandant la 10e Region vous portant à l'ordre du jour de cette région. Vous y trouverez avec les félicitations du Général Marion, celles du Directeur des Service de Sauté de Rennes.

Permittez moi comme Médecin Chef de Service à l'hôpital Militaire de Lannion d'y joindre avec les mieunes, celles du personnel médical de l'hôpital. Nous sommes trés heureux du témoignagne officiel de distinction donné à l'un des nôtres et nous en sommes frères avec vous.

Le Médecin Chef de Service,
(Signé) LE GUEULT.

7th Field Ambulance,
3rd Division,
British Expeditionary Force,
Friday, October 30th.

To Stanley Cock, Esq.

I daresay you know that G. D. and self sailed about the 20th September. We met Maitland Scott and Hampton on board. We had great luck, for two days after landing we were sent up to the front. I was attached to this division, and G. D. (Eccles) and Scott went to the 5th. Since then we have been absolutely in the thick of it! ! I never thought that when we used to rot about in the " Yacht " that I should become so used to the shriek of the shrapnel and the noise of the Jack Johnsons' as to hardly take any notice of them! ! ! I got in for the last few days of the Battle of the Aisne—then we did about a week of night marching, and for the last fortnight we have had most strenuous fighting here day and night.

There are a very nice lot of fellows here, and I have a horse—fortunately a very quiet one—and a servant, so am pretty comfortable. I went a few days ago as M.O. to the Worcester Regiment as their M.O. had been badly wounded and there wasn't another up here.

The first day a distillery just by my dressing station was set on fire! most uncomfortable for me with forty wounded men in a barn! but thank goodness we escaped with only four men killed.

That night a general retirement was ordered and the Worcesters took up an entrenched position with orders to hold it at all costs!

My dressing station was 300 yards behind the trenches in fairly good cover. For five days they shelled us almost incessantly with shrapnel and " Black Marias " and if you just put your head round the corner a bullet would come over it! ! We only went out after dark unless it was very urgent. I used to go down in the evening and at dawn to report to the C.O. and at night we used to get the wounded out of the trenches—rather heavy work as the Germans would keep throwing up their rockets, and we never knew when they would make a night attack! ! One morning as I was coming back from headquarters along the ditch the snipers caught sight of me, and bullets fairly whistled over my head. I have not run so fast for a long time, and in doing so ricked my old ankle.

Another morning I went out . . . . just behind the dressing station where I thought I was quite safe and a bulled whizzed past me just as I was in the middle of it. It acted wonderfully . . . . ! The snipers seem to get into houses behind one's own lines in an extraordinary manner.

I am very fit and well despite the wet, last night, for instance, I spent from 12 to 1 a.m. with my bearers in a trenc ı half full of water—we went up for wounded and got in for a night attack.

Eccles was with the 15th F. A., and is now M. O. to the East Surrey's. I caught sight of Jamie Stewart for a minute, he is M. O. to the Gordon's—he would be very annoyed with me if he knew I said so.

PHILIP SMITH.

Letter from an Orderly in the R.A.M.C. to his former colleagues in the Works Department.

Boulogne.

Mr. Davis & Co.

Well chaps one and all, at last I have the opportunity of answering your letter for which I was very pleased. The chaps here laughed at the nom-de-plumes at the end of your names. Well, am pleased to tell you that I am going on A1 and seeing plenty of life—and death. I had a little sport the other day at " Ypres " we were waiting there on the station for wounded and a couple of German aeroplanes flew over us—dropping bombs—one went through the hospital in town only just outside the station and another through the roof of a café, killing several patients in the hospital and shattering one side of the café to smitherines, killing a horse in the stable. I left the station to go in to the town to see the café and damage done.

There were hundreds of men, women, children, and troops there at the time we were looking at the café, and all of a sudden a fusillade of rifle fire began, three more Taubes flew over, bombs all over the shop. Well, you should have seen us *skidadle* like scalded cats. It was pitiful to see the women and children crying, terror stricken, and running in all directions to get from directly underneath them. There happened to be a few hundred troops here at the time, and what with the din of their fire, the bursting of the bombs, and the terrific artillery fire of the battle going on about 1½ miles away, it was a scene!

They dropped one bomb close to the end of our train, killing one Frenchman. It fell in between the lines and made a large hole—we searched for souvenirs and I got two bullets and a small piece of metal from that one—on the whole I enjoyed it, it was a change and livened

us up a bit. It is very tame this train work we see nothing but dead, dying and wounded, the same thing everyday, we don't go right up to the fronf, we go as far as we dare with safety, and our field unit's field ambulances bring in the wounded by road motor ambulances to the train where we load and carry to the base which is Boulogne at present. I have had a good trip round to Boulogne, Amiens, close to Paris, Versailles, seen the Eiffel Tower and Notre Dame Cathedral, Orleans, Havre, St. Nazaire, Nantes, they are the main, and any amount of others round the front. I was in Belgium last week at Poperingue and Ypres.

I have a "Hun's" helmet and a couple of long bayonets if I can get them home. Well, I don't hardly know what I can put on the *sheet* this week; we are doing double time, no time to wash a shirt. We are all chatty. Roll on Angleterre! It is impossible to keep free, the wounded are absolutely *chatty* when they come on the train. The coaches are thoroughly sluiced and scrubbed out with strong cresol every time we empty, and that is all we can do till more come in, and then in come the *chats* again "*Young Kaisers.*"

Well! how is young Harry going on? Has he joined the "Scarts" or "Stand Backs" yet? He is better off where he is. It is a devil of a job to write while the train is on the run so you must excuse scribble. We are travelling now to somewhere, I know not where. I have to write like this to have it ready to post at the other end. This is a proper rag-time railway—get your inside jerked out—the poor patients don't half go through it at times, fractured thighs, arms and abdominal wounds. I sometimes think we have left the metals and are running on the roadway. They have a fine system of railways here, but the track is in bad condition.

Well, now, chaps, I must close for the time being. I have done my best under the circumstances, and trust you are all going on well and keeping good health. I am grand myself, and often think of you all about 3 to 3.30, can picture the "old urn."

Well, good bye, chaps; will let you have another later on.—I remain, yours truly, W. D. MORRIS.

No. 4 Ambulance Train,
Expeditionary Force,
c/o G. P. O.

H.M.S. *Shark*,
C/o G.P.O., London,
October 25th.

Just a line, as promised, to let you know how I was getting on. I've been waiting for something exciting to happen, but work is very quiet and I've only had a few septic things and earache.

The last chap aboard in my position was so ill that he completely collapsed and had to be sent to a hospital ship. Luckily for me I've not been affected at all, tho' wee've not met really bad weather yet.

They have fitted me out with a delightful set of instruments and hypodermic things—one syringe in a cover for pinning into the coat ought to be rather useful.

As far as asepsis is concerned I'm afraid I can only boil the instruments before an action and keep them in a tin box which I shall also sterilize before hand. But as I shall have to crawl about the deck doing what I can washing the hands continually is out of the question. I'll have to pin my faith to iodine—and trust to luck. Hoping things are going well at Guy's.—Yours very sincerely, A. F. G. GUINNESS.

Nursing News.

MATRON'S OFFICE.

There are now 101 Guy's nurses serving abroad or on hospital ships.

On 16th November Sisters Surgery, Esther, and Lazarus, and Misses Todd and Finlow joined the French Flag Nursing Corps to work in the French *Military Hospitals.*

On Friday, November 20th, Nurses Barker (Guy's Institution), Goodchild, Phillips, Southcote, and Twose are expecting to be called up by the War Office for service abroad.

Nurse Hanmer (Guy's Institution) has commenced work at the Military Hospital, Woolwich, and Nurse Gibson (Guy's Institution) is awaiting orders for foreign service through the St. John's Ambulance Society.

Extracts from a letter to Matron from Sister Kiddle will interest all, in spite of the letter being long delayed on its journey, and doubtless there have been many changes at Versailles since it was posted on the 28th September, 1914:—

"We are at Versailles, which I expect you know; no time to see the town, but can pass through the grounds on our way to and from the hospital. We feel quite a little 'Clinical' here. Each ward has its own medical officer, and who should be ours but Mr. Passey. Sister Beardshaw is on night duty in my ward, and since both she and Mr. Passey were in Clinical it is just a little like old times.

"It is so strange being installed in an up-to-date building and struggling to do up-to-date nursing with about one-tenth the things one needs badly to do it with, but we really manage excellently. None of us regret having given up our soft jobs, and we none of us mean ever to say we know what hard work is again, because our Tommies have shown us what that really is.

"They are splendid; how I wish that you could come to my ward on your way round of a morning; you would love to have a chat with some of my men. One cannot do enough for them, poor fellows. What they have gone through in some instances is inconceivably awful, and their faces show this.

"Some of them have been wounded three or four days and even longer before they get to us, so you can imagine the state they are in, and yet they are cheerful. A few of them cannot forget the sights they have seen, and live through it continually. Their state of mind is dreadful; the younger ones seem to feel it least.

"We are beginning to realise what a truly dreadful game war is. Why should a civilized people stoop to such a means of settling disputes. To see the way these men are brought along in train loads lying on straw makes me shiver. Imagine fractured femurs and far worse jolting along for two or three days in such a state.

"When we arrived at the Trianon Hotel, our future hospital, the hotel staff were still removing furniture, and the R.A.M.C. men were busy unpacking the whole of the hospital equipment. We came out quite expecting to work under army people, but here we are in charge of our own wards and running them as much like Guy's as possible.

"My ward consists of one side of a long corridor, with fifteen rooms, each room taking from two to five patients, and each having a little balcony. Both the air and the view from the windows are lovely, and, of course, much nicer than tents from the patient's point of view. Unfortunately the floors are covered with Brussels' carpets, which are spoilt already, and the worry of my present existence if I happen to have time to look at them.

"My patients were forty on the first day, but the next day eight more beds were sent up, and a week later we had hurriedly to make up 25 more in the corridor. I have one nurse from the Derby General Hospital and one nursing and one working orderly, so you can imagine how busy we are. Mr. Passey is splendid in helping us all day long. I have three patients who know Guy's well, and one that was quite a frequent visitor to Clinical when his sister was in 'Miriam.' I remembered him at once when I caught sight of him as they were bringing him in, and he was so pleased to find someone he knew. He has a nasty compound fracture of the femur, but is doing well and has got to the stage of taking interest in the war news.

"We had a busy time getting our ward ready. We set apart a bathroom as surgery, a wardrobe (not removed by the hotel staff) as linen cupboard, and a second wardrobe as store cupboard, and then had to get them stocked. 'Kits' (I never want to hear the word again) are not supposed to be given out until the patient arrives; however, I got most of the things required, linen, crockery, etc.

"Before sending to the dispensary for ointments, etc., we hunted round the deserted kitchens and came across a nice stock of little brown earthenware jars with lids, which made excellent pots. They would look quite smart in Out-Patients on a Tuesday afternoon. I also commandeered some marble topped tables, bedroom jugs, and basins, and they have been more than useful. By 5 o'clock we were quite straight and ready for anything.

"Although the arrival of the ambulance has become quite a common sight, it is by no means less grim. How glad I am their people do not see them as they arrive here. The colonel, with a big book, stands on the steps, with him are a major, captain, and the R.M.O.'s of the different wards. Outside the sergeant is most busy getting stretcher bearers and orderlies into position. Inside beds are turned down and quarts of hot milk, etc., ready, and the theatre awaiting any emergency. The first ambulance draws up and the stretcher bearers remove the first patient. The major finds out, roughly, what is wrong, the colonel decides where he shall go, and the captain (who is R.S.O. and surgeon-in-chief) gives orders. The R.M.O. follows the cases to his own ward. In less than two hours nearly 300 poor fellows are admitted. The whole proceeding is too awful and too real to describe.

"Never shall I forget that 'take-in' to my own ward—some walking, some carried, some on stretchers, all in one continuous stream. There was no time for undressing, and we found ourselves with a ward full of patients on the beds, but by no means in them.

"Then came the great task of getting them undressed and into bed. They were all so dirty, tired, hungry, and some so ill, even apart from their injuries. They had been marching for days on practically nothing, and then had a hard fight at the end of it. Some arrived with hardly anything on; one man had half a coat and a hat, one leg had been amputated on the field, and he was looking just awful, but so pleased to be put comfy in bed and to get a hot drink, and, above all—a smoke. He got on splendidly for the first 24 hours, and then the following morning his jaw was stiff and he had one or two nasty spasms, and you can guess the rest—have truly stepped from 'Clinical' to a second 'Clinical.' We tried everything, of course, but Dr. Shipway's continuous oxygen and ether is by far the nicest treatment. We are trying serum as a preventative, and not as a curative now; the Pasteur Institute presented the hospital with an unlimited supply.

"We have since had four others admitted too bad to do anything, but I don't want to tell you about them it was all too sad. This is only one of our patients but am not going to tell you any more horrors about the others, only nice things. They were all splendid, and I just wish you could have seen us, we went round and sorted out those who were really bad, three only had to go to the theatre immediately, no time for half-hourly pulses, etc., and attended them first. They had all come along lying on straw and quite a quantity managed to stick to their clothes, so that by the time we had them undressed the rooms resembled a stable rather than a bedroom of a first class hotel. Their socks had shrunk so around their ankles that it was quite impossible to remove them without the aid of scissors; this caused great amusement, and one man looking like a 'teddy bear' would call out to another resembling 'shockheaded Peter' 'after you with the cutters Jock,' and many pairs of socks were chopped from many poor sore feet.

"One wanted to wash all of them there and then (the men I mean, not the socks), but no time to think of that until the more necessary part of the work was performed. The fractured femurs, etc., we fixed into temporary splints padded at the bedsides, they were all compound with several other wounds and most difficult to fix comfortably without our old friend 'Hodgen.' The men were simply splendid and did not murmur, although the pain they had to bear must have been enormous. Some of the wounds one could do little to until they had been X-rayed, etc., the shrapnel were the nasty ones, the bullet being marvelously clean.

"I wonder if you have seen a piece of shrapnel, it is fiendish stuff and plays great havoc wherever it manages to lodge. Iodine was the order of the day, and it has proved a great success, have not seen one clean wound go wrong—this would please Mr. Saner. We came off about 3 a.m. leaving Mr. Passey and Sister Beardshaw still very busy. In the middle of all these happenings we were attending the usual 'Infusion of Saline,' etc. How nice it would be if we could only command as many pairs of hands and feet as we sometimes feel we need, I would like at least three instead of a miserable one.

"By 8 a.m. next morning we were busy again, the men felt better already for their rest, and all the next day they did practically nothing but sleep, they were just tired out. There was still no time to think of washing all the poor things properly, the bad ones of course we did thoroughly, and you cannot imagine how awful it felt to do only just what was necessary for the rest. When we had got things fairly straight, our Medical Officer appeared on the scene, and we were very busy for the remainder of the day doing dressings and fixing up apparatus for splints, etc. It was quite three days before all our patients were able to have a good wash, of course it makes things much more difficult having rooms instead of one big ward, and to begin with we had to boil all our water, as the boilers of the hotel were not working, now we get a good supply of hot water which is a great comfort. As soon as our men are well enough to be moved we send them to the tents in the grounds, where they remain until they are well enough to be transferred to the Base and either home to England or back to light duty.

"Last Monday we had to transfer thirty at a moment's notice as we heard that a convoy of wounded were expected. We had news about twenty-four hours beforehand that they were coming, but the transports were so delayed that we almost ceased to expect them. We returned to the hospital after supper and awaited their arrival which began about 11.30 p.m., thirty stretcher cases were sent to me, all very bad, and it was really quite difficult to know which to attend first, it is just awful how you are on the continual watch for one dread symptom, how you spot it at once, isolate it immediately, and yet with all one's careful treatment, what result—none that is good.

"I want to tell you all sorts of things about the treatment we are using for our patients, but the Censor would not pass my letter. I guess he will get somewhat tired of this one. All our second batch of patients were in the same fight as the first and most of them wounded at the same time, so that they were not in nearly such good condition, some have been lying in the trenches for days, some had crawled into a forest, others were put into a church and quite a number into a big cave, practically nothing to eat and getting very little sleep, except where too exhausted to keep awake. One poor man, the only survivor of his corps, had crawled about from hedge to hedge during the night for two weeks with nothing to eat except one tin of bully-beef and what else he could find on the roadside. His wounds were awful, and all this time of course were not attended to, so perhaps you can picture what he was like, poor chap; I don't think he ever realized even when he was with us that he was safe again, his face was too sad to describe and he looked just like some poor haunted animal. Another man was very badly burned by a shell bursting by the side of him in the trenches. His head, face, chest, back, hands and arms are very badly burnt, and he is quite delirious and lives through everything again: it makes me creep—it takes over an hour to dress him every day, so have to do a little bit at a time, everyone declares he is not going to do, but he just must: he's a splendid fellow and he really is no worse than he was three days ago."

In a letter dated October, Sister Kiddle reports that the man who was so badly burned was discharged cured—"a great triumph, we are very proud of him."

A post-card received 14th November, 1914, from Miss Paterson (Sister Jentie) states that she has been transferred to No. 5 Clearing Hospital. "Four or five large convoys in, fed, dressed, some washed, clothes changed, and most out (*i.e.* drafted elsewhere) in twenty-four hours. Some huge dressings.

I am thankful for my medical equipment. The glass syringes have done noble work, they travel in a pair of bed socks. Last night I could hardly sleep for sound of guns. To-night I watched the flare on the sky. We are a picnic on the edge of the world!"

Guy's Nurses.

A boy scout running across the entrance court at Guy's Hospital one day last week would have been evidence enough that there were sick and wounded there even if one had not known it before. The nursing staff are naturally delighted at the arrival of the soldiers, and those who had been feeling that in comparison with the nurses at the front they had not enough to do, now have their part to play. Forty-eight officers are now being nursed in Stephen ward, which has been divided into cubicles. This is the ward in which the new rubber flooring has recently been laid, and it is proving its value, we learnt from Miss Haughton, in its warmth and the freedom from clattering noises which it ensures for the patients. As soon as it was known that the accommodation was wanted by the War Office the Works Department became busy; some partitions taken down from the old quarters of the wardmaids (for whom a new house has just been opened) were scrubbed and cut for the cubicles, and in twenty-four hours the ward was ready and the patients arrived. As the ward has its own operating theatre it is peculiarly suitable for the purpose. Sir Arbuthnot Lane was the first surgeon in charge.

About 200 nurses trained at Guy's are now on active service at home and abroad. These include about forty-five who have been enrolled in the Civil Hospitals Reserve called upon by the War Office. The following have gone out recently:—Miss E. F. Beloe (Matron, Sudbury Cottage Hospital), Bessie H. Daniels (Sister Ruth), Louisa A. Robinson, Martha Nelson, Elsie E. Quilter, Winifred Warner, Gladys Cosby, Nora Hiles, Evelyn Moriarty, Amelie Macara. Among the sisters who have gone to the front is Sister Densham, the Assistant Matron. The names of the Guy's nurses have appeared in the various lists we have given of the Red Cross units, and other parties sent out, while a large number are in the Q.A.M.N.S. Reserve.—*Nursing Times*, Nov. 14th.

Reviews, etc.

A Manual of Physiology. By G. N. Stewart. (Ballière, Tindall & Cox.) Seventh edition, 1914. Demy octavo; plates, 1 coloured and 467 figures in text. Pages xxiv. and 1,132. Price 18s. net.

Physiology has shown a remarkable development in this country and America during the last twenty or thirty years. A steadily increasing recognition of its importance as a preliminary to clinical work has been witnessed in all the medical schools. No longer does

one hear jeering remarks about the muscular twitch of a frog's muscle or the electromotive changes of nerve. Both the physicians and the physiologists have become wiser; they have learnt from one another. The physiologist does not now dream of solving the enigma of life by an intensive study of isolated muscle and nerve, but recognises that the body works as a whole, not as the sum of its isolated organs and tissues. The physician extends the knowledge of his subject by experiments of a physiological nature, for in increasing measure he finds that pathological conditions have their representations in physiological processes.

In some of the American Universities this recognition of the value of physiology is shown in the appointment of physiologists as Professors of Experimental Medicine and as Clinical Physiologists to the Hospitals. Professor G. N. Stewart occupies such a position, and his well-known "Manual of Physiology," which has now reached a seventh edition, reflects the clinical aspects of the subject. If the book be examined from this point of view it will be found to contain a far more comprehensive account than that found in most of the text-books. The special feature of the book, the practical exercises, does not appeal to the English teacher or pupil, for it is more convenient to use special books for practical work in experimental and chemical physiology.

The book is well illustrated, but the index, although it is extensive, requires revision. The subjects of one section—Sleep and Hypnosis, page 947—are not given in the index.

Extraction of Teeth. By F. Coleman, L.R.C.P., M.R.C.S., L.D.S. 2nd edition. (H. K. Lewis, 136, Gower Street.) Price 3s. 6d. net.

This book, divided into three chapters, and dealing exclusively with the operation of extraction of teeth, is one of the best published. The first chapter is devoted to the technique of extraction of teeth, the second to the difficulties, complications, and sequelæ of tooth extraction, and the third to the extraction of teeth under anæsthesia. The article on Local Anæsthesia is of much interest, and it is extremely gratifying to find that the practical side of this operation is not sacrificed to the theoretical side.

Mr. Coleman is to be congratulated on the lucid manner in which he expresses himself. The book is well printed, contains many good illustrations, and is of a very convenient size.

A Complete Hand-book of Midwifery for Midwives and Nurses. By J. K, Watson, M.D. Third edition. Thoroughly revised. With over 150 Illustrations. Price 6s. 6d. net.

Most nurses are familiar with Dr. Watson's books, and midwives should welcome this edition of his "Handbook of Midwifery." The text has been carefully revised, the object of the author evidently being to make the midwife as familiar as possible with the theory of her subject, which is sometimes forgotten in the practical part of her work. Dr. Watson is, perhaps, inclined to give "too much," rather than "too little," but the midwife who is keen on her work will find she is easily able to assimilate the knowledge which is set forth in such a clear and simple manner, and the book is one which should be of considerable practical use to her. The illustrations are good and numerous.

Essentials of Physiology. By F. A. Bainbridge and T. Howarth Menzies. (Longmans, Green & Co.) 1914. Pages viii. and 434. 134 Illustrations. Price 10/6 net.

This is a new book which will be welcomed by both teacher and pupil. It is a very useful work, for it brings together in a concise form the fundamental facts and principles of Physiology. It incorporates the most recent advances and contains many excellent illustrations. On the whole there is a well balanced consideration of the different systems; the sections on circulation and respiration are good examples, but the secretion of milk is worthy of far more space, especially in a book for medical students.

Essentials of Human Physiology. By D. Noel Paton. (W. Green & Son). Fourth edition, 1914. Pages xxiii. and 557. 213 figures in text. Price 12s. net.

This is another text-book in which the object is to emphasize those parts of the science which are of cardinal importance in medicine and surgery. The work has been revised and brought up to date; it has now reached its fourth edition. The style is clear, but, owing to the limitation of space, it is too concise and dogmatic. Many medical students will consider this characteristic as an advantage, but there is little doubt that they would be better prepared to grasp the difficult problems of disease if they learned to estimate the value of evidence.

Handbook of Anatomy for Students of Massage. By Margaret E. Björkegren. (Balliére, Tindall & Co.). 3s. 6d. net.

In presenting a Handbook of Anatomy for Students of Massage, Margaret E. Björkegren is filling a long felt want. Students in preparation for the Incorporated Society of Trained Massueses examination can not do better than obtain the same, as it appears to cover most of the ground necessary. The illustrations are clear and should be found very useful. The general description of contents as far as they go, is good.

We would suggest in the next edition, which will certainly be looked for, that the general action of the muscles should be more definitely gone into, and perhaps in the illustrations marking of muscle attachment to bone would more clearly impress the memory. We congratulate Margaret E. Björkegren, and are confident her work will prove to be of great benefit to students.

Death.

MARSH.—At Hove, on October 24th, George Ryding Marsh, M.D., in his 57th year.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

HIS MAJESTY THE KING, Our Patron, has sent a present of wine to the Hospital this week. Quite recently a quantity of game was also received. These gracious acts are typical of the care which Our Sovereign bestows upon his subjects. Despite the heavy Duties of State, Our King finds time to perform acts of practical sympathy every day. "Probably there is no influence so powerful as sympathy in awakening the affections of the human heart. There are few, even of the most rugged natures, whom it does not influence." At a time when Patriotism is stirred to the utmost, the sufferings of the sick are remembered, and workers in the cause of charity are spurred to even greater efforts. We offer our heartfelt thanks to His Majesty for this act of Royal kindness to the Hospital.

ALL Guy's men and nurses will be interested in the report of the Guy's Maternity Charity which has been prepared by the Lady Superintendent, and is published in this GAZETTE. This report deals with the "nurses' side" only. Almoners' work is conducted by the Out-Patients' Visitors Office, where enquiries are made and deserving cases are submitted to the various charitable organisations.

Old externs will be glad to hear that a "Queens' Nurse," supported by the Guy's Maternity Charity, resides at the St. Olave's District Nurses' Home, and gives her whole time to nursing work on the "men's side;" cases being allotted to her by the Charity.

GREAT improvements have now been instituted in the Massage Department. New regulations having necessitated many changes and extensions. The original building is being repaired and fitted with apparatus which will enable a greater number of Out Patients' to be treated every day, and, more cases of spinal curvature will have medical gymnastics. There has been recently a considerable increase in the number of this type of case attending the Orthopædic Department.

Extensions have been made possible by removing the ward maids' to Tabard House, and utilizing the large space over Bright and Queen Wards. The room over Bright Ward has been improved by the addition of five windows which overlook the Park. The floor space is 80 feet by 16 feet, and has been converted into a school room and gymnasium, completely equipped with all the apparatus necessary. There are two courses of Massage in the year, beginning respectively in November and June, six months before the June and November examinations for the Diploma.

Several new appointments have been made:—Mr. Trethowan is Supervisor and Lecturer on Massage; Mr. Bromley, Lecturer on Anatomy; Dr. Pembrey, Lecturer on Physiology. The Resident Masseuses are:—Miss Angove, Sister in Charge, and an Assistant who is a certificated

medical gymnast snd masseuse. In future, non-resident students will do the massage for the Hospital, both for In-Patients' and Out-Patients' under the supervision of their teachers.

Those who require further particulars should write for the published brochure which describes the aims and scope of the department in detail. We have abstracted the following interesting information from it:—

> Massage "has been practised from time immemorial, and by the most primitive peoples, but has from time to time fallen into disuse amongst Western nations."
>
> The Swedish Gymnastic System instituted by Ling is based upon a Chinese text-book, and Paracelsus in 1591 "gave a description of methodical Massage as practised by the Egyptians quite on modern lines."
>
> Later refinements of the treatment are stated to be chiefly due to Metzer of Amsterdam, whilst its application by Dr. Weir Mitchell in combination with the "rest cure" for hysterical and other nervous conditions did much to gain public appreciation of its utility.
>
> As regards Guy's Hospital, Massage was first systematically practised and taught in 1888, and six years later the establishment of the Incorporated Society of Trained Masseuses raised the status of the professional Masseuse, obviated certain abuses which had arisen, and ensured a higher degree of manipulative skill, based upon a sounder knowledge of Anatomy and Physiology. Recently, the Society has inaugurated a system of inspection of Training Schools with the intention of securing good hygienic conditions, and a nearer approach to uniformity of teaching; and in the near future no candidates will be admitted to examination except such as have been trained in Schools approved after inspection.
>
> There are many advantages in associating the teaching of Massage with a large General Hospital and Medical School. Under these conditions it is practicable to obtain for the courses of Anatomy and Physiology the services of those who are engaged in similar work in the Medical School, and whose scientific researches may prove to have important bearings upon the best use of Massage and Exercises as a means of physical culture and a remedy in suitable cases for deformity and disease.
>
> A large General Hospital with its Surgical and Orthopædic Out-Patient Departments has always under observation a considerable number of patients suffering from fractures, dislocations, scoliosis, &c., for whom Massage and Gymnastics may usefully be prescribed, and the abundant facilities thus afforded for clinical work will enable Pupils of the Massage School to supplement their theoretical instruction by that wide practical experience in the actual handling of patients which is essential if the highest excellence is to be attained.
>
> Moreover, amongst In-Patients further opportunities are given for experience in the treatment of fracture cases confined to bed, and of nervous and other medical conditions, to which general Massage and Remedial Exercises are appropriate.

Lieutenant-Colonel Ferdinand Campion Batchelor, M.D., has recently arrived in England with the New Zealand Colonial Corps, although he is now over seventy years old. He is an old Guy's man, Professor of Surgery at Otogo University, and was formerly on the Staff of the Dunedin Hospital. He qualified in 1871. In 1891 he published "Notes of One Hundred Cases of Abdominal Surgery" in the *Australian Medical Journal*. His son, Ferdinand Stanley Batchelor, qualified in 1897, held the posts of H.S. and Obstetric Resident, and is now in practice at Dunedin.

Another old Guy's man, Dr. G. H. Percival, is resigning his appointment as Medical Officer of Health for the Northampton Rural District after 36 years service. He has received the cordial thanks of his Council who much regret his retirement.

Dr. Percival qualified in 1871. In 1887 he recorded a successful Case of Ligature of the Carotid and Subclavian Arteries for Innominate Aneurism in the *British Medical Journal*, and also a Case of "Suture of Ruptured Bladder," *Ibid*, 1887.

We offer our hearty congratulations to Dr. Walter Ramsden on his appointment as Johnston Professor of Bio-Chemistry at the University of Liverpool. After a distinguished undergraduate career at Oxford, Mr. Ramsden entered Guy's in October, 1893, and obtained the Treasurer's Medal in Medicine in 1896. His election to a Radcliffe Travelling Fellowship in 1898 obliged him to spend some time in medical study and research abroad. He returned to Oxford as Demonstrator of Physiology and was elected to a Fellowship at Pembroke College; recently he was appointed University Lecturer in Chemical Physiology.

Mr. L. A. Dunn resumed his duties at the Hospital on Monday last. His official teaching round is on Thursdays, at 1.45 p.m. By the way, we should like to point out that three excellent articles, written by Mr. Rutherford Morison, on "Surgical Teaching," appeared in the *Clinical Jonrnal* on the 11th, 18th, and 25th of November.

The Bradshaw Lecture will be delivered by Sir Frederick Eve at the Royal College of Surgeons on Tuesday, the 15th of December, at 5 o'clock p.m. precisely. The subject of the lecture will be "Acute Hæmorrhagic Pancreatitis with remarks on the Etiology of Chronic Pancreatitis."

At the recent Final Fellowship Examination, 37 candidates presented themselves and 10 were admitted to the Fellowship. We offer our hearty congratulations to Mr. G. S. Miller, the successful Guy's candidate.

As we have announced previously, there will be no Residents' Theatricals this year. It is proposed instead to organize two entertainments which will take place on the evenings of December 28th and 29th; only outside talent will be relied upon. Tickets will not be issued, as they are usually, for the theatricals, but invitations will be sent out later. It has been decided, after some discussion, that the "Niggers" shall go round as usual on Christmas Day.

Owing to expense and other reasons the Out-Patient Department will not be decorated this year in the same way as it has been in former years. The Committee of the Out-Patient Fund will be very glad to receive flags to be used instead of the decorations so kindly given in previous years.

Captain M. A. Rahman, I.M.S., and Lieutenant H. C. Rook, R.A.M.C., are at present warded in the Officers' Section.

Captain W. R. Reynell has recovered from his operation and is now recuperating prior to resuming his duties with the Australian Field Hospital.

Second Lieutenant A. K. Day-Lewis, 9th Battalion West Yorkshire Regiment, has been appointed President of the Royal Army Temperance Association at Belton Park, Grantham.

All the Guy's Orderlies at No. 2 Base Hospital are shortly proceeding to France to take up new medical duties.

We shall be pleased to send the Gazette to Guy's men or Nurses on active service. Will those who desire copies kindly communicate with the Editor?

There will be no Christmas picture this year. It is hoped, at the conclusion of the war, to publish a supplement with photographs of all Guy's men who fall in the service of their country.

Christmas Presents.—A list of Etchings, Prints, and Portraits, suitable for Christmas Gifts will be found on an advertisement page of this Gazette.

Mr. Winston has arranged Cards, Books, and Crests, etc., on a table in his room in the Library. The pictures are displayed on a board opposite to the room.

The Christmas Cards produced by Messrs. Ash & Co. at 2d. each are a great improvement on those of former years. The Guy's crest is on the cover which is very well designed, and over leaf is a picture of one of the parts of the Hospital.

Wingent.—The Borough and the Borough Hospitals, 1912. 3s. 6d. net.

Wilks and Bettany.—History of Guy's Hospital, 1892. Price 21s. and 10s. 6d.

Various Christmas Post Cards at 1½d. each.

Various Christmas Cards with the Guy's Crest on the Cover and a photo of one of the parts of the Hospital inside at 2d. each.

Guy's Hospital Armorial Bearings, beautifully coloured; framed 3s. each, unframed 1s. 6d. each.

Guy's Hospital Crest on wood, 5s. each.

A Case of Poisoning due to the Prolonged Use of Picric Acid for Scalds.

LILY —, aged 24, unmarried; admitted on November 1st, 1914, for scalds on the chest and arms. Previous diseases: Diphtheria and pneumonia when a child; had enjoyed good health subsequently. History of present accident: The patient was leaning against an urn in the bar of a public-house where she was employed; the urn slipped, spilling boiling water on the chest and arms. On admission there was an extensive burn of the first, second, and third degree on the front of the chest and one slight burn on the front of each elbow. In other respects patient was quite healthy. The urine was not examined. Several bullæ were opened and a dressing of lint soaked in a 1 per cent. watery solution of picric acid was applied. This relieved the pain immediately; inflammation became less, and patient was discharged on the 4th of November feeling quite well. On discharge the burns were quite clean and not inflamed, but a picric acid dressing was left on the wounds. Patient came up to the surgery on the 5th and also on the 7th of November and picric acid dressings were re-applied. She came up again on the 9th of November complaining that she could not sleep and that the wounds itched very much. There was no diarrhœa or abdominal pain, but a patchy erythema exudativa was present on the neck and face and on the wrists and back. The patient felt sick, and fainted in the surgery. She was seen again on Tuesday the 10th at Skin Out-Patients and re-admitted.

On admission she was very distressed: temperature 101.2; pulse 104; respirations 24. The rash was confluent in the face, chest, and back, and there were patches in the legs. The wound on the chest looked quite clean. Urine was very deep red in colour. Hot boracic fomentations were substituted for the picric acid. On the 11th the temperature and pulse became normal and have remained so. The rash began to disappear, and when patient was examined on Saturday the 14th the rash had gone and was replaced by areas of desquamation. The peeling was not ringed, but consisted of small irregular flakes. Unfortunately the urine was not examined by Dr. Ryffel until Saturday the 14th. It was bright yellow in colour, sp. gr. 1018; albumen and picramic acid absent; urobilin a trace. Patient was discharged a few days later. Throughout the illness she was not jaundiced.

Unfortunately the urine was not examined early enough to detect the presence of picramic acid, but there can be little doubt that we are dealing with a mild case of poisoning due to the continuous application of picric acid for nine days. We believe that this is the first case of picric acid poisoning occurring in Guy's, certainly no cases have been recorded, and Sir Cooper Perry had not previously seen one.

The case is of sufficient rarity that we append a summary of the literature.

Although picric acid is used in the form of lyddite, in the manufacture of shells, these will only explode when a detonator is employed, and the danger to be apprehended from the use of picric acid in surgery seems hardly justified. In France it is used in the form of melinite in the manufacture of shells, and our own experience justifies us in saying that it may be heated to its melting point or struck with a hammer without exploding. In France forty thousand shells have been made at one factory without a single accident. In England much more care is exercised, and the workmen wear special clothes and work in danger buildings. It is true there are restrictions on the sale and storage of this substance, but these do not apply if it be in solution. A few cases have been recorded showing that some people exhibit a pronounced idiosyncrasy to this drug, especially when applied to burns, but this would hardly arise when applied once or twice for skin sterilization.

BOOTH, A. W. Some uses of Picric Acid in Surgery. *Internat. J. Surg.*, N.Y., 1904, xvii., 160.

"A yellow, crystalline, bitter substance soluble in acetone, alcohol, ether, chloroform, and water.

First employed as an antiperiodic, used in India in the treatment of malaria; 1 dr. by the mouth causes vomiting and purging, but a healthy adult can safely take 10—15 grs. t.d.s.

An anthelmintic and has been used for exophthalmic goitre. It has, however, never had extensive use as an internal remedy. Penetrates deeply into the tissues, and Booth considers that its value depends not so much upon its antiseptic properties as upon its power to coagulate or tan the tissues, especially in infected wounds produced by streptococci such as we encounter in erysipelas and septicæmia. It coagulates lymphatics and prevents general absorption.

Used in gynæcological and genito-urinary practice with good results."

The use of oil for burns and scalds dates from remote antiquity. It was familiar to Hippocrates, and the notion has prevailed even in the minds of the laity that oily protection is absolutely necessary. Dr. J. H. Ryffel has pointed out to us that the virtue of carron oil lies in the alkali which it contains.

Various attempts have been to medicate oil or vaseline by incorporation with boric acid, zinc oxide, and the like. The rational method should be to keep clean all damaged tissue and form some protection to the underlying tender layers. Grease in any form macerates the tissues and affords lodgment for putrefactive germs. Picric acid forms an antiseptic scab and has analgesic properties. After the first few hours there is no raw surface. It is very cheap, and an ounce bottle of the dry crystals could easily be kept in a medicine case. The stains are easily removed by strong borax or weak caustic soda solution.

Picric Acid as an Aid in the Treatment of Various Skin Lesions. *Arch. of Pediatrics*, 1913, xxx., 87-9.

Wilcox says it is almost specific and the danger of untoward results negligible.

In Eczema.—In acute cases with exudation, excoriation, and crusting, improvement most marked. In milder cases an aqueous solution is painted on several times daily, and allowed to dry. In severe cases wet dressings are used. Lessening of pain and itching immediate, reduction of scabs and softening of crusts. Not so useful in subacute and chronic cases, but cure of lesions hastened by treatment initiated by two or three days application of picric acid solution, which increases the effectiveness of ointments containing zinc, tar, salicylic acid, calomel, mercury.

Intertrigo.—Cured twice as rapidly as with icthyol solution. So satisfactory that it is used as a routine by maternity nurses whenever buttocks are red or excoriated.

Dr. Cameron uses it in cases of *exfoliative dermatitis* in children with successful results.

Not so uniformly successful in erysipelas, but in certain ways more satisfactory because it lessened discomfort and pain and œdema disappeared more rapidly. In several cases there was a desquamation of cast-like masses leaving healthy skin beneath. Reduction of temperature was the rule with or without improvement in the local condition.

Herpes labialis.—More rapid drying up of the lesions, and fewer extensions of the trouble.

With the exception of immediate and constant relief from itching, children with *psoriasis* showed no definite response to the treatment.

In Impetigo.—Better results were obtained with antiseptic ointments than with picric acid washes. Picric acid ointment was not used in these cases.

AGNES SAVILL. Value of Lotion, Picric Acid, vii. gr., Camphor, ½ oz., Rect. Spirit, ½ oz., in Treatment of Ringworm. *Practitioner*, 1913, p. 94.

X-rays more certain and rapid, but unsafe except in hands of an expert. Apply with brush, wash yellow powder away and re-apply twice a week. Epilation must be carefully performed.

MILWARD, F. V. A Note on some Further Uses for Picric Acid. *B.M.J.*, 1903, i., 422.

F. V. Milward found that the lesions for which it is most useful were those in which a loss of superficial epithelium has produced a raw and painful sore, discharging serum and sero-pus, the weeping surface best seen after eczematous conditions.

The rationale of the treatment seems to be the formation of a pellicle of coagulated albumen over the wound and the protection of the superficial lymph spaces and exposed nerve endings. Should active inflammation be present there is a danger of confining micro-organisms under the protective coating and giving rise to further inflammatory trouble. In cases where pus is already present, *e.g.*, in acute eczema, it is not a suitable remedy.

It is best used as a saturated solution 1—95 of distilled water.

In a case quoted in which picric acid was applied to an acute eczematous condition of the hand after mopping away the visible pus, a lymphangitis and small abscesses in the arm developed. Picric acid must not be used indiscriminately.

CALVELLI. *B.M.J.*, 1889, i., p. 678.

Says it is useful in erysipelas, lymphangitis, eczema rubrum, and erythema.

ALLEN. *B.M.J.*, 1897, i., p. 457.

Speaks of its use with good results in cases of eczema of the legs, recent wounds with much loss of skin, and in capillary and hæmophiliac hæmorrhage.

F. V. MILWARD wished more particularly to point out its use in minor and trivial cases of loss of the superficial epidermis.

In perionychia affecting the roots of the nails a few threads of white gauze soaked in a saturated solution of picric acid is pushed to the bottom of the cavity exposed by separating the margin of the soft tissues from the base of the nail, and is renewed three times daily. Two or three applications render soft corns quite painless.

To cure ingrowing toenail, remove the offending sharply-pointed part of nail which is digging into the ulcerated soft parts. Picric acid will harden and render the latter insensitive and make complete removal of the nail unnecessary. Good results were obtained in cases of intertrigo, especially when this condition affects the interdigital clefts of the toes. Picric acid had more antiseptic and penetrating qualities than zinc oxide, starch, boric acid, and iodoform which form crusts under which pus may collect.

ELLIOT AND BEVERS. A Case of Picric Acid Poisoning followed by severe constitutional symptoms. *Lancet*, 1906, 1175, 1336.

Girl, aged 14, scalded by boiling water. Burns on both arms, on the elbows, and above and below were found of the second and third degree. Slight burns of the second degree on the forehead, round the right ear, and on the back of the neck. Blebs were pricked, and wounds dressed every second day with a saturated solution of picric acid.

She progressed well until October 1st, when the tongue became furred, lips dry, expression anxious, sickness ensued, and the temperature rose from normal to 102.4, pulse from 88 to 154, conjunctivæ yellow, and the whole skin slightly icteric. A rash was found over most of the body, bright red in tint, papular

and non-hæmorrhagic. The rash was partly discrete and partly confluent, and had the appearance of measles. It was distributed in discrete form over part of the neck, and the whole of the chest, the abdomen, and the back, arms as far as the wrists, the front of the thighs, and a few patches over each ankle and the toes. It was well marked and confluent over the sides of the chest, both buttocks, the back of the thighs, the calves, and the inside of the knees. There was no rash on the face (as in our case), the hands, or the front of the knees.

The urine passed that morning was acid, sp. gr. 1022, clear and bright red, with a greenish shimmer on the surface. An examination of the blood showed an anæmia of the red cells and an eosinophyle leucocytosis. The dressing was changed to boric ointment.

On October the 5th the temperature had fallen to 100.1 and pulse to 130. Patient seemed better, but the sickness continued. The rash was more pronounced and more confluent, conjunctivæ a deeper yellow, and urine dark brown. On the 6th, temperature 99.1, pulse 96, rash beginning to fade. In parts there was evidence of slight hæmorrhage into the papules; conjunctivæ not so yellow, and urine dark brown.

The rash continued to disappear from this date and was invisible by the 12th. Patient progressed favourably until the 14th when she was again seized with vomiting and looked ill. She complained of abdominal pain and was tender on palpation, temperature normal; bowels open with an enema, no blood in stools or vomit. She improved from this date, and was discharged on the 24th and remained at home quite well for a week. She then developed pain in the "stomach" and was sick three times.

She was re-admitted on November 3rd obviously extremely ill, and having severe abdominal pain. For three days there was no improvement, she vomited blood, passed blood in the stools, and the urine was smoky and gave the blood reaction with guaiacum. There were a few petechiæ on the forearm. On the 7th she was better, and then improved rapidly, being home again on the 29th quite well except for a cloud of albumen in the urine.

Remarks by Dr. ELLIOT—

Symptoms supervened only on applying picric acid for seven days, and ceased when it was discontinued. The rash resembled measles, but was absent from the face and behind the ears. It was extremely well marked on those parts of the body in contact with each other and also where subjected to pressure. In other cases described there has been severe constitutional disturbance, rapid pulse, rise of temperature, rash, yellow tint of conjunctivæ and skin. One showed vomiting and diarrhœa, another showed all the above symptoms except the rash. In all cases urine dark red, dark green, or port wine, and in all symptoms have abated on discontinuation of the dressing.

Picric acid is trinitrophenol formed by the action of nitric acid on phenol. Picric acid has the effect after absorption of combining with the hæmoglobin of the blood corpuscles and displacing the weaker combination in them of hæmoglobin, thus preventing the normal metabolism of the tissues.

Professor Erb found distinct nuclei in the red discs and free nuclei in the serum. White blood corpuscles show a tendency to numerical increase. The urine is frequently red in colour; the poison is mainly eliminated by the kidneys, and the changes in the urine are due to the changes which occur in the blood. The urine in Dr. Elliot's case was examined by Dr. Ramsden of the Oxford Physiological Department. The first sample was rich in some abnormal pigment. This pigment was carried down with the earthy phosphates precipated by heat, the precipitate being a rich brown colour. The exact nature of the pigment could not be ascertained, but tests for hæmatoporphyrin, methæmoglobin, and hæmatin proved negative. We are not aware of any evidence that an idiosyncrasy in respect of such drugs as picric acid, carbolic acid, or iodolorm exists, though possibly such may exist.

The occurrence of instances of poisoning does not prohibit the use of such medicaments, but indicates that they must be used with caution. In the *Lancet,* August 5th, 1891, an instance was reported of a man who worked in a melinite factory and inhaled fumes of nitrous acid and volatilized picric acid. Severe dyspnœa ensued with cough and spasm of the glottis. Picramic acid was found in the urine; parenchymatous nephritis followed, and death ensued.

W. E. T., Ed. G.H.G.

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* In the Library of the Royal Society of Medicine.
† In the Wills Library.

An Investigation of the Germicidal Properties of Picric Acid.

IN a recent number of the GAZETTE Mr. Philip Turner recorded his belief that a 1 per cent. solution of picric acid in methylated spirit was just as efficient as ordinary iodine solution for skin sterilization and was only about one-tenth the cost. Picric acid penetrates more deeply into the skin than tincture of iodine and is thus more effective in destroying organisms in the deeper layers of the epidermis and in the sweat glands. Mr. Rowlands does not find iodine a sufficient cleanser of lacerated muscles.

By the courtesy of Dr. Eyre, the GAZETTE, assisted by Mr. J. C. Turner, has investigated the germicidal properties of picric acid in vitro. Later we hope to test the sterility of skin after treatment with picric acid and to estimate how quickly the germicidal power of picric acid is decreased when it is in actual contact with living tissue or wound.

EHRENFRIED (Journal A.M.A., vol. lvi., Feb. 1911) investigated the germicidal action of aqueous saturated solution of 1.2 per cent. crystallized picric acid in boiling water and found this solution to be approximately 50 times more germicidal than 1 per cent. phenol solution. These results were confirmed by O. W. H. Mitchell (Germicidal and Osmotic Actions of Picric Acid, Ann. Surg., Phila., 1911), who states that picric acid is a strong germicide and no untoward result from the application of a 1 per cent. aqueous or alcoholic solution to large areas of skin. It was used for skin sterilisation in 78 cases, and the only disadvantage found was that in a few cases one or two small points of delayed union occured owing to small coagula of serum forming between the edges of the wound and hindering union mechanically.

FONTANA (Journal A.M.A., October, 1911, p. 1429) found picric acid quite as effective as tincture of iodine and much more convenient for sterilising the hands. Picric acid solution has strong osmotic powers, and is capable of passing through rubber gloves. This osmotic power is of great importance in connection with its germicidal effect on bacteria in contact with living tissues as compared with results obtained in vitro.

In our investigation the aqueous solution taken was that used in the hospital for the treatment of burns. The alcoholic solution was that used by Mr. P. Turner for skin sterilization. The test organisms were staphylococcus aureus, streptococcus longus, bacillus pyocyaneus, and bacillus coli communis, all virulent stains recently isolated from the gunshot wounds of patients in the Officers' Section.

The tests were carried out on the lines of the Rideal-Walker method, using carbolic acid as a standard control. No attempt was made to determine the germicidal powers of iodine, but for comparison one set of tests were prepared, using bacillus coli as the test germ. The method used was as follows:— 5 c.c. of the germicide is measured into a sterile test tube and to this is added 0·1 c.c. of a culture of the test germ. After $2\frac{1}{2}$ minutes contact 0·1 c.c. of the mixture is transferred to a tube of nutrient broth. The process is repeated at intervals of $2\frac{1}{2}$ minutes until the length of exposure arranged is reached. The inoculated tubes are then incubated at 37° C., and examined at intervals of 24 hours.

TABLE I

Organism employed: Bacillus Coli Communis

Culture Medium: Broth — Age 24 hrs. Temp. of Incubation 37° C

Quantities used { Culture Emulsion } 0·1 c.c. + 5 c.c. Germicide.

Date ..... Room Temperature during Experiments .....

Germicide.	Strength.	Time of Exposure in minutes: 0	2½	5	7½	10	12½	15	17½	20	30	Incubation: Time.	Temp.
Picric Acid	Aqueous	+	+	+	+	+	+	+	+	0	-	48	hrs
" "	Alcoholic	1%	0	0	0	0	0	0	0	0	0	37	°C
" "	"	0·5%	+	0	0	0	0	0	0	0	0		
Phenol	1–100		+	+	+	+	+	0	0	0	0		
"	1–110		+	+	+	+	+	+	+	+	0		

TABLE II

Organism employed: Streptococcus Longus

Culture Medium: Broth — Age 24 hrs. Temp. of Incubation 37° C

Quantities used { Culture Emulsion } 0·1 c.c. + 5 c.c. Germicide.

Date ..... Room Temperature during Experiments .....

Germicide.	Strength.	Time of Exposure in minutes: 0	2½	5	7½	10	12½	15	17½	20	30	Incubation: Time.	Temp.
Picric Acid	Aqueous	+	0	0	0	0	0	0	0	0	0		
" "	Alcoholic	1%	0	0	0	0	0	0	0	0	0	48	hrs
" "	"	0·5%	0	0	0	0	0	0	0	0	0	37	°C
Phenol	1–100		+	0	0	0	0	0	0	0	0		
"	1–110		+	+	+	0	0	0	0	0	0		

TABLE III

Organism employed: Bacillus Pyocyaneus

Culture Medium: Broth — Age 24 hrs. Temp. of Incubation 37° C

Quantities used { Culture Emulsion } 0·1 c.c. + 5 c.c. Germicide.

Date ..... Room Temperature during Experiments .....

Germicide.	Strength.	Time of Exposure in minutes: 0	2½	5	7½	10	12½	15	17½	20	30	Incubation: Time.	Temp.
Picric Acid	Aqueous	+	+	+	+	+	+	+	+	+	+		
" "	Alcoholic	1%	0	0	0	0	0	0	0	0	0	48	hrs
" "	"	0·5%	0	0	0	0	0	0	0	0	0	37	°C
Phenol	1–100		+	+	+	+	+	+	0	0	0		
"	1–110		+	+	+	+	+	+	+	+	0		

TABLE 4.

Organism employed Staphylococcus Aureus.

Culture Medium Broth Age 24 hrs Temp. of Incubation 37°C

Quantities used { Culture Emulsion } 0·1c.c. + 5c.c. Germicide.

Date Room Temperature during Experiments

Germicide.	Strength.	Time of Exposure in minutes. 0	¼	5	¾	10	12½	15	17½	20	30	Incubation. Time.	Temp.
Picric Acid	Aqueous	+	+	+	0	0	0	0	0	0			
"	Alcoholic 1%	0	0	0	0	0	0	0	0	0		48 hrs	
"	0·5%	0	0	0	0	0	0	0	0	0		37°C	
Phenol	1-100		+	+	+	+	0	0	0	0	0		
"	1-110		+	+	+	+	+	+	+	+	+		

TABLE 5

Organism employed Bacillus Coli

Culture Medium Broth Age 24 hrs Temp. of Incubation 37°C

Quantities used { Culture Emulsion } 0·1c.c. + 5c.c. Germicide.

Date Room Temperature during Experiments

Germicide.	Strength.	Time of Exposure in minutes. 0	¼	5	¾	10	12½	15	17½	20	30	Incubation. Time.	Temp.
Picric Acid	3%	0	0	0	0	0	0	0	0	0		48 hrs	37°C
Phenol	1-100		+	+	+	+	0	0	0	0	0		
"	1-110		+	+	+	+	+	+	+	+	0		
Boric Acid (Saturated)			+	+	+	+	+	+	+	+	0		
Permanganate Alcoholic	1%		0	0	0	0	0	0	0	0	0		
	0·5%		+	0	0	0	0	0	0	0	0		

In the above tables a + sign indicates growth, *i.e.*, test organism living, and a — sign no growth, *i.e.*, test organism dead.

CONCLUSIONS.

1. Aqueous solutions of picric acid were practically useless with most of the test organisms; only the more delicate bacteria, *e.g.*, streptococcus longus, were killed after five minutes' exposure.

2. Alcoholic solutions of picric acid possess strong germicidal powers; even with a 0·5 per cent. solution the test germs were destroyed after five minutes' exposure.

3. The 1 per cent. alcoholic solution of picric acid might be used in the treatment of sepsis in gunshot and shell wounds. We hope surgeons will use this solution and record their results. If necessary a stronger solution, say 5 per cent. in alcohol or acetone, could be used.

W. E. T., Ed. G.H.G.

The following notes on a case of picric acid poisoning, brief and incomplete as they are, may merit publication:—

Elsie B., aged 7 years, attended my Out-Patients at the Evelina Hospital for ringworm on May 20th of this year. She was given a strong picric acid ointment to apply to the patches. It should be mentioned that during the preceding December and January she had been treated with the picric acid lotion, suggested by Dr. Winkelried Williams and so strongly recommended by Dr. Agnes Savill in the *Practitioner* of July, 1913. This treatment, however, had been discontinued at the end of January.

On May 21st, *i.e.*, one day after the ointment had been given her, the child was brought up again to the hospital, the mother complaining that "the ointment had gone all over her body and into her eyes." On examination she was apparently jaundiced, her skin and conjunctivæ being bright yellow. Salicylates were prescribed, and the mother was told to bring her child up again to see me on the following Wednesday.

When I saw her she was still of a bright yellow tint all over, and was in a drowsy condition. I fancied that the picric acid had in some way caused jaundice. The child was admitted, and it was then found that her urine was of a dark reddish tint. It contained, however, neither bile pigment nor blood, and Dr. Leathem, pathologist to the hospital, reported that no hæmoglobin derivatives whatever could be detected. The fæces were also of normal colour.

It was suggested that the colour of the urine was due to the presence of creatinine picrate, and possibly to picrates of salicylic acid, salicylates having been taken by the mouth during the preceding week. The patient remained drowsy for three or four days, after which time the urine regained its normal appearance. She was kept in the hospital for seventeen days, and on her discharge the discolouration of the skin and conjunctivæ had nearly faded. For some time afterwards, however, the child seemed below par, but has now recovered completely. Her ringworm was treated by the X-rays early in July, and is now cured.

Although this was undoubtedly a case of picric acid poisoning, it is inconceivable that it can have occurred in twelve hours by absorption from the scalp. It is evident, I think, that the child must have taken some of the ointment by the mouth.

H. W. BARBER.

Change of Address.

Capt. G. T. Willan, R.A.M.C. (T.), care of Messrs. Holt & Co., 3, Whitehall Place, S.W.

E. C. B. Ibotson, M.D., B.S., Bron y Craig, Corris, Merioneth.

W. G. Brett, Villa Lamberti, San Remo, Italy.

Dr. P. H. Ward, from N'dola, N. Rhodesia, to Lusaka, N. Rhodesia.

Obituary.

Dr. WILLIAM REGINALD CAZENOVE.

We regret to announce that Dr. William Reginald Cazenove, of West Norwood, died of enteric fever at the South Western Fever Hospital after a short illness on November 18th, aged 40.

Dr. Cazenove entered Guy's in October, 1893, and qualified in July, 1899. After qualification he went to Northampton as Assistant Medical Officer to the St. Andrew's Hospital. He was subsequently in practice at Long Sutton, in Lincolnshire, and later moved to West Norwood, where he was at the time of his death. He leaves a widow and three children.

He warmed both hands at the fire of life. This phrase is perhaps the best epitaph on one of the most human and lovable of the men who have passed through Guy's in the last twenty years. Tall, short sighted, and stooping, by his manner of speech and facile gesture of hands and shoulders, he betrayed his mixed French, American, and Irish descent. His sense of humour for the same reason was a strange combination of the Quartier Latin and Chicago. Music was a second nature to him, and no one who was in the Charities' room in the years 1895 to 1898 will forget the sight of William at the piano every evening after dinner, pipe in mouth, and one leg crooked behind the chair, his long thin fingers sprawling over the keys while he played anything from Wagner and Chopin to the latest musical comedy or popular song.

He was the leading spirit in all that was done at Guy's in those years, being one of the most popular and successful of the "Disguysed" Minstrels, who collected over £1,500 for the hospital funds in two Christmas seasons by means of nigger minstrel entertainments in London and the suburbs; he was also one of the foremost contributors to the *Guyoscope*, a witty students' paper that achieved notoriety and success, not only inside Guy's but also in the outer world.

It may no longer be in existence, but for years "Neckinger Nora," a national anthem for Guy's externs, composed for a smoking concert in honour of the late Dr. Horrocks after a *cause celèbre* in the law courts, was sung on festive occasions by generations of students who had never known the author.

He never made an enemy and never lost a friend, and all his old acquaintances will hear of his death with infinite regret.

Papers by Guy's Men.

Francis E. Shipway, M.D.: Intratracheal Anæsthesia. —*Lancet*, November 28th, 1914.

Pass List.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, OCTOBER, 1914.

J. B. Dunning. | W. M. Lansdale.

SUPPLEMENTARY PASS LIST.

The following candidate has passed in group II.—

F. A. Beattie.

Royal College of Surgeons.

PRIMARY EXAMINATION FOR THE FELLOWSHIP IN ANATOMY AND PHYSIOLOGY.

L. S. Debenham.

FINAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY.

J. M. Barnes.	*E. C. Lewis.
*P. E. Bernhard.	W. G. Lloyd.
D. A. Bevis.	A. E. Lowein.
W. E. Coe.	*J. L. Mugford.
C. J. Crocker.	*P. T. Pearce.
A. C. Dean.	L. P. Richards.
*M. G. Henry.	*D. F. Small.
*J. J. S. Hill.	*H. V. Stebbings.
P. E. Jessop.	F. E. Welton.

S. A. Withers.

*Part I only.

Society of Apothecaries.

MIDWIFERY.

R. Curle.

Notices.

University of London.

THE Senate of the University passed the following Resolutions at its Meeting on the 18th November, 1914:—

1. That military service during the war be counted as equivalent to not more than two Terms of a Course of Study in Military Science for Internal Students in any one of the three years over which such Course of Study would ordinarily extend.

2. That, in the Session 1914–15, in the case of an Internal Student entering for an examination of the University, 120 hours of military training in the University of London Contingent of the Officers' Training Corps, duly certified by the Commanding Officer, be counted as equivalent to 25 per cent. of the hours of attendance prescribed for the Student's course of study in that Session.

3. That, during the continuance of the war only, the Second Examination for Medical Degrees, Part I., be held in December as well as in March and July.

Guy's Hospital, 24th November, 1914. H. C. CAMERON, Dean of the Medical School.

The Visual Field and its importance in General Medicine.

CLINICAL LECTURE BY H. L. EASON, M.D., M.S.

Gentlemen,—Though it is not to be expected that every physician or general practitioner should have a special and expert knowledge of diseases of the eye, or of the use of the ophthalmoscope, there are certain methods of investigation which should be used as a matter of routine in every case of intra-cranial disease or of disease of the general nervous system. Of these the most important and the most useful is the routine examination of the visual field, and with the view of impressing this upon your minds I propose to-day to give some short account of the normal characteristics of the field of vision, and of its definite and regular affections.

For the accurate record of the visual field it is usual to have some form of perimeter, or apparatus for charting in graphic form the field of vision, and of these by far the best is McHardy's registering perimeter, which is the standard instrument in use. But for the visual defects which I am going to discuss to-day it is hardly necessary even to use this, as a rough examination of a patient's area of vision can be made quite satisfactorily by the use of a square of white paper on one's hand, the patient's gaze, one eye being closed, being directed to the observer's eye. By observing the patient's ability or inability to see the movements of the object in the periphery of the field of vision, a very good general idea can be obtained of any considerable defect as compared with that of the observer's own field.

Before considering the pathological defects of the visual field it is important to bear in mind some facts as to the normal characteristics of human sight. The normal extent of the visual field is probably familiar to all of you. If you shut one eye and look straight ahead with the other eye, you find that the area of the field of vision is limited on the inner side by the nose and by the supra-orbital region. On the outer side of the field you can see a great deal further round; in fact, you are able to see as far as, or even a little farther than a line at right angles to the direction in which you are looking: that is to say, to an object placed on a line a little behind the ear. Below, the field is limited by the lower margin of the orbit and of the cheek, and above by the supra-orbital region, the extent of the visual field being limited in this direction proportionately to the prominence of the orbital region and the eyebrows.

You do not, however, see with equal distinctness all over the field of vision; you only see distinctly what you look at directly: that is to say, there is a great difference between merely seeing a thing and looking at it. Looking at an object means that the eye is so directed that the image of the object looked at falls upon a definite point in the centre of the retina, practically on the posterior pole of the eye. This spot is termed the macula, or yellow spot, and is the only part of the retina that is capable of really acute vision.

The area of the field of vision in which objects are really seen distinctly or clearly is extremely minute, being little larger than the area of one's thumb nail held at arms length; but one is not usually cognisant of this fact because a complete visual impression can be taken in an extremely limited period of time, and the movement of the eyes, and the consequent sequence of definite visual impressions is extremely rapid. In the remainder of the field vision is only approximately good: one can see objects, and to a certain extent, colour and movement; but there is little or no perception of detail. Generally speaking, therefore, in broad daylight the field of vision can be divided into a small central area in which vision is very acute for form, and also for colour, and a peripheral area in which vision is much less acute, and in which, with ordinary illumination, colours are much less distinctly seen. It is an interesting fact, however, that in minimal illumination central vision is not so acute as peripheral; for example, on a dark starlight night you can appreciate a fact which has been known to astronomers for hundreds of years, namely, that faint stars can be better seen when you do not look at them directly. Take as an instance the constellation of the Pleiades, a group of stars of low magnitude: though the stars are not very close together, if you look directly at them you have some little difficulty in counting them, but if you direct your gaze a little above or below the constellation, the stars seem to stand out more brightly, and you can count them better. As a laboratory experiment also, if you put a small white square on a dark velvet background in a very dimly lighted room you will see a square of paper much more distinctly with indirect than with direct vision.

In connection with these facts I want you to bear in mind the cognate anatomical fact that in the yellow spot of the retina, the area devoted to acute central vision, there are cones in great number and no rods, and towards the periphery of the retina the rods become more numerous and the cones less so. It seems probable, therefore, that the characteristics of central vision, efficiency in high illumination, acute form and colour sense, are due to the cones, and that the characteristics of peripheral vision represent the function of the rods, viz., comparatively poor vision for form and colour, but rather increased efficiency compared with the cones in minimal illumination. In confirmation of this theory it may be noted that the rods are much more numerous in the retinæ of nocturnal animals and birds.

We have now to consider the path of the nerve fibres from the retina to the brain. Fig. 1

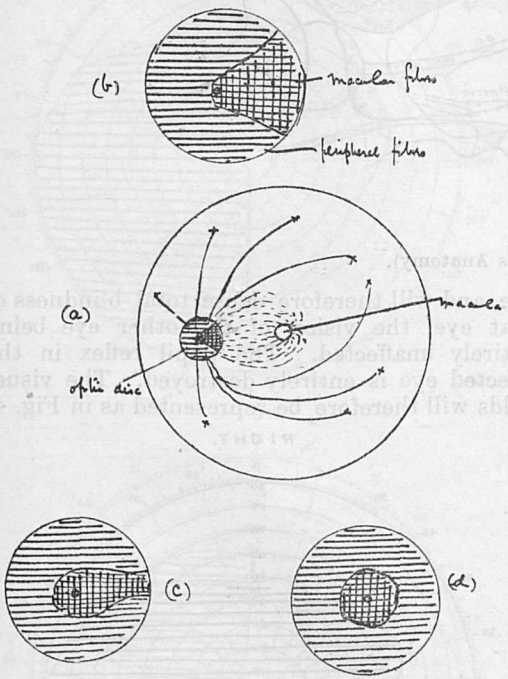


FIG. 1.

shows diagramatically the course of the macular fibres; they start from the ganglion cell layers in the retina and run from the macula to the outer part of the optic disc, forming a triangular segment on its outward side. The fibres from the peripheral parts of the retina make up the rest of the optic nerve. Sections of the optic nerve further back show that this triangular key-stone shaped bundle of macular fibres gradually takes up a position in the centre of the optic nerve; so that generally speaking it may be said that the macular fibres are those which are associated with the central portion of the field of vision, and are the axial or central fibres of the optic nerve. In connection with this central position of the macular fibres, it is important to remember that the blood supply of the optic nerve is derived not from the central artery of the retina, but from the pial sheath of the nerve, a sleeve or out-growth of the pia mater of the brain. The vessels run into the optic nerve in connective tissue trabeculæ or partitions which break up the optic nerve into numerous large bundles. Hence in arterial disease and in conditions in which the blood supply of the optic nerve is damaged in any way, the central or macular fibres of the optic nerve are the most liable to suffer as being the furthest away from their blood supply. The fibres of the two optic nerves join, as you know, at the chiasm, where there is a semi-decussation rather like a diamond railway crossing, the fibres from the nasal half of each retina and each optic nerve crossing to the opposite side, those from the temporal side passing round to the same side of the brain without crossing (Fig. 2). These rearranged optic nerve

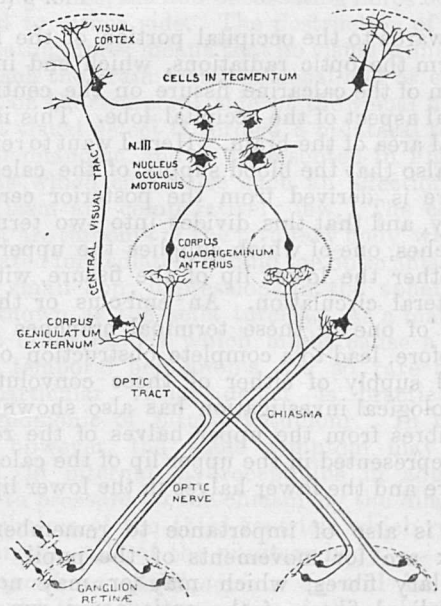


FIG. 2 (from Quain's Anatomy).

fibres now form the optic tract of each side, and their further course is best shown in Fig. 3. The optic tract winds round the crus of the cerebral peduncle and ends in the external geniculate body and the corporate quadrigemina; here the long axis cylinder processes which arise in the ganglion cell layer of the retina come to an end, completing the lower neuron of the optic tract.

Fresh visual nerve fibres start in the corpora quadrigemina and geniculate bodies, turn sharply upwards to the posterior part of the hinder limb of the internal capsule, and spread

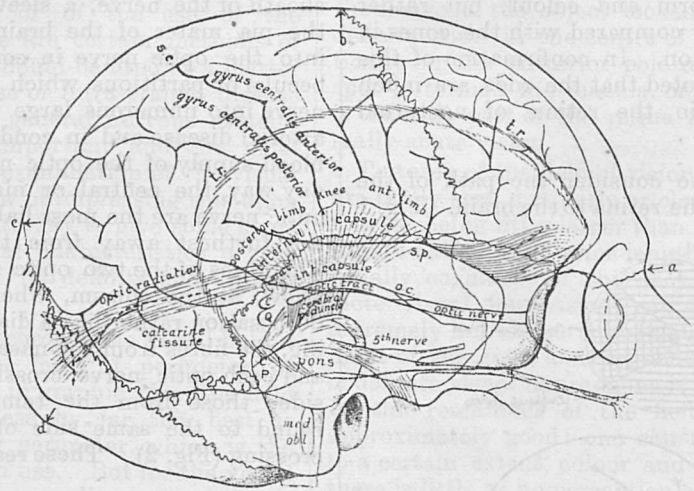


Fig. 3 (from Quain's Anatomy).

backwards to the occipital portion of the brain to form the optic radiations, which end in the region of the calcarine fissure on the centre or mesial aspect of the occipital lobe. This is the visual area of the brain. Here I want to remind you also that the blood supply of the calcarine fissure is derived from the posterior cerebral artery, and that this divides into two terminal branches, one of which supplies the upper and the other the lower lip of the fissure, without collateral circulation. An embolus or thrombosis of one of these terminal branches may, therefore, lead to a complete obstruction of the blood supply of either of these convolutions. Pathological investigation has also shown that the fibres from the upper halves of the retinæ are represented in the upper lip of the calcarine fissure and the lower halves in the lower lip.

It is also of importance to remember the reflex arc for movements of the pupil. The pupillary fibres, which may or may not be specialised fibres of the optic nerve, run from the retina through the chiasm and up the optic tract as far as the anterior quadrigeminal body. Here they leave the optic tract and run to the third nerve nucleus. From here they proceed down the third nerve to its inferior division, and then by the long ciliary nerves to the sphincter of the pupil.

Let us now consider the possible lesions of the optic tract, and their effect upon the visual field.

1. *Lesions situated between the optic chiasm and the eye itself.* It will be seen at a glance from Fig. 2 that a lesion in this situation will destroy all the visual fibres running from one eye, and will therefore cause total blindness of that eye, the vision of the other eye being entirely unaffected. The pupil reflex in the affected eye is entirely destroyed. The visual fields will therefore be represented as in Fig. 4.

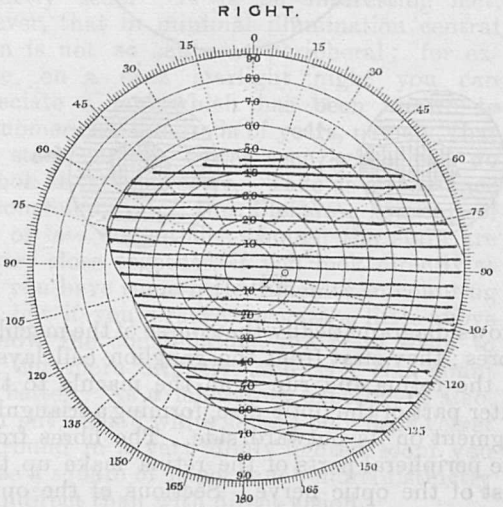


Fig. 4.

2. *Lesions of the optic tract between the chiasm and the corpora quadrigemina and geniculate bodies.* In this case it will be seen that a lesion will destroy the fibres of one or the other optic tract. That is to say, fibres going from similar or homonymous sides of the retina in the two eyes. This will give rise to what is known as a homonymous hemianopia, one side of the field of vision being affected in each eye. For example, a lesion situated in the right optic tract will detroy the fibres going from the right-hand side of the retina in both eyes. Now, the right-hand side of the retina corresponds with the left-hand half of the visual field, and the lesion will therefore cause a left homonymous hemianopia, and the visual fields will be represented by Fig. 5. It is easy to

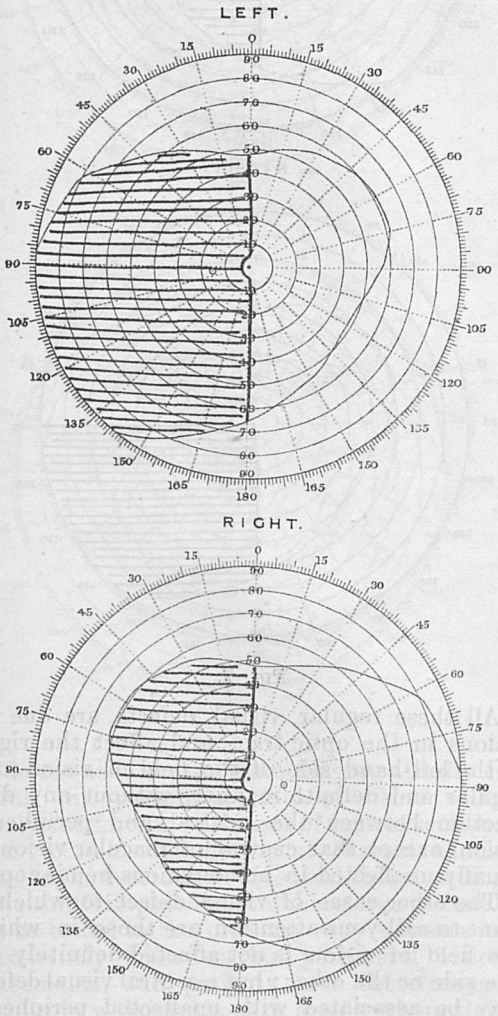


Fig. 5.

remember without drawing a diagram in every case which side of the field of vision will be affected in a lesion of this sort, if one bears in mind what would happen with a corresponding lesion in the motor tract. A right-sided lesion causes paralysis of the left side of the body; in a similar way an affection of the right optic tract causes blindness on the left-hand side of each field of vision. A lesion situated in this position not only destroys the optic tract, but also breaks the pupil reflex arc for the blind sides of both retinæ. Consequently when a beam of light is thrown upon the blind side of the retina there is no pupillary reflex, though the reflex is unimpaired from that half of the retina which still sees. In contrast with the symptoms of such a lesion, one should consider next a lesion in the right optic tract, but above the quadrigeminal and geniculate bodies, and between them and the occipital cortex. Here, as in the previous case, there will be a left homonymous hemianopia; but the pupil reflex arc will not be affected. Hence a beam of light will cause a pupillary reflex, even when thrown on the blind side of the retina. The presence or absence of this hemianopic pupillary reflex is therefore of great value in localising the cause of a homonymous hemianopia.

3. *Lesions in the neighbourhood of the chiasm.* A lesion situated at the chiasm and pressing on it tends to destroy the decussating fibres, the non-decussating fibres being pushed to either side. The destruction of the decussating fibres means that no visual stimulus can reach the brain from the nasal half of each retina, or the temporal side of the visual field. Such a visual defect is termed a bi-lateral temporal hemianopia, and is represented in Fig. 6. Lesions which can cause such an affection of the chiasm are comparatively few. The commonest are tumours of the pituitary body, which is situated immediately behind the optic chiasm, in the small bony depressions in the sphenoid bone known as the sella turcica. As a matter of fact other lesions which might cause a bilateral temporal hemianopia are so rare that this particular visual defect is practically pathognomonic of pituitary tumour. In rare cases, however, the same symptom may be caused in internal hydrocephalus in adults, owing to pressure on the chiasm by the dilated infundibulum of the third ventricle which runs down in the stalk of the pituitary body.

4. *Quadrant hemianopia.* It will be remembered that the upper lip of the calcarine fissure corresponds to the upper half of the retina, and the lower to the lower half of the

retina, and that these convolutions are supplied by terminal branches of the posterior cerebral artery; and in cases of embolism or thrombosis of either of these branches one may get, instead

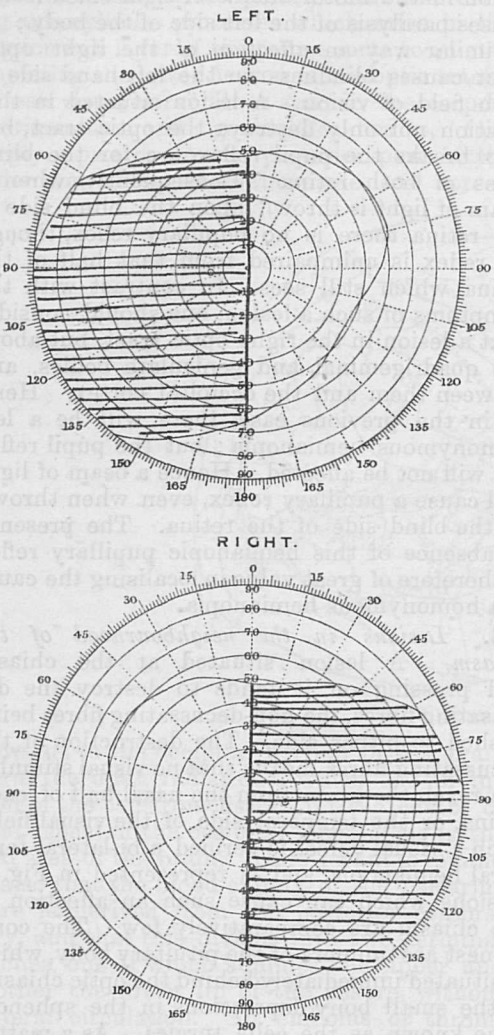


FIG. 6.

of a homonymous hemianopia, a homonymous quadrant of the field of vision affected. Fig. 7 represents a right inferior quadrant hemianopia. The affected portions of the field correspond with the left upper quadrant of each retina, and these quadrants are represented in the upper lip of the left calcarine fissure. Such defects of the field of vision may occur in migraine and cerebral endarteritis, and I have under my care at the present time a British officer, hit on the left side of the skull in the occipital region by a rifle bullet which did not penetrate the bone, who suffers from a precisely similar defect. In his case the visual defect is probably due to a contusion or hæmorrhage in the upper lip of the left calcarine fissure.

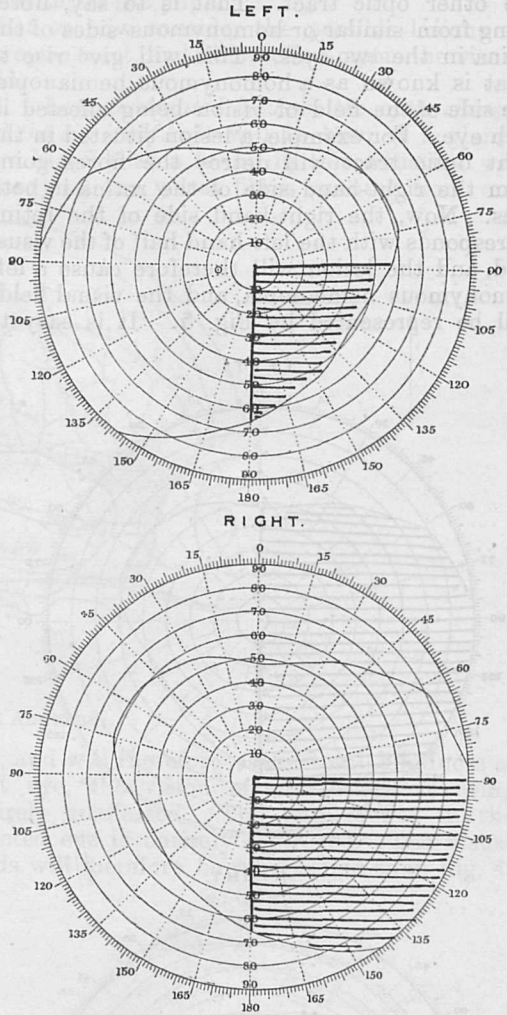


FIG. 7.

All these regular visual defects are due to lesions in the optic tract, and affect the right or the left-hand side of the field of vision in a regular and definite manner, without any distinction between the central and peripheral vision, except that central or macular vision is usually unaffected in homonymous hemianopia.

The other cases of visual defect to which I want to call your attention are those in which the field of vision is not affected definitely on one side or the other; but a central visual defect may be associated with unaffected peripheral vision or vice versa.

A central defect in the field of vision is termed a central scotoma, and sometimes only affects vision for colour, though in many cases vision for form, reading and writing is also affected. The typical field of vision is represented in Fig. 8.

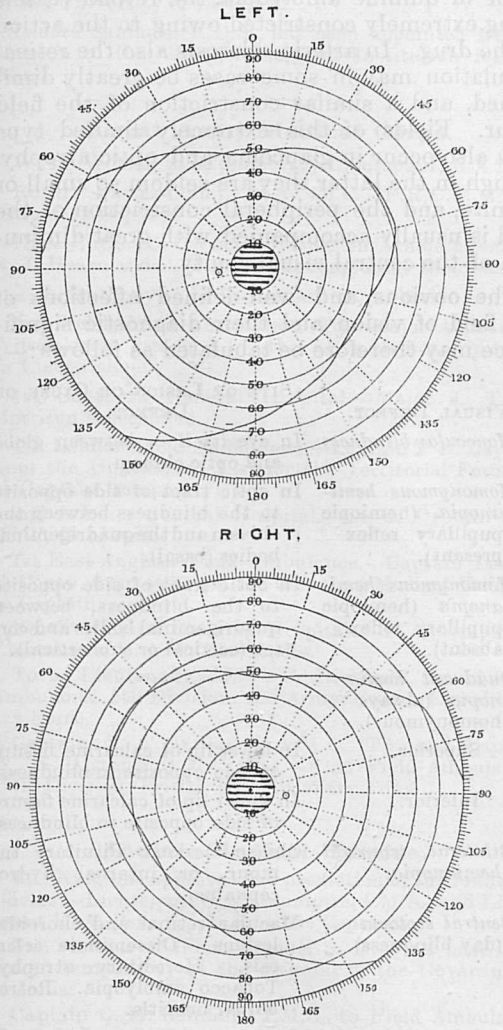


Fig. 8.

The defect as is shown there diagramatically is central, the peripheral field of vision being entirely unaffected. All cases of central scotoma present certain definite visual characteristics. Owing to the destruction of central vision reading and writing is impossible, and therefore a patient's sight as tested in the ordinary way appears to be extremely defective, but peripheral vision still remains, and patients have therefore no difficulty in walking about or seeing where they are going. Owing to the destruction either of the cones or the retina itself, or of the nerve fibres connected with them, colour vision will be gravely affected in the centre of the field, or entirely destroyed, and vision will be better in a dim light, when the rods are at their greatest efficiency, rather than in a bright light. Hence all patients suffering from central scotoma are affected more or less with day blindness or hemeralopia.

A central scotoma may occur in cases where there is a definite retinal or choroidal defect in the region of the macula; but these are of no particular interest to us on this occasion. A central scotoma is found most regularly in *disseminate sclerosis*, occurring according to Professor Uhthoff in about 25 per cent. of all cases of disseminated sclerosis with visual defect. It may also occur in a certain form of optic atrophy (*Leber's atrophy*), which is hereditary and affects young adults, the optic atrophy in these cases seldom progressing beyond the central scotoma, and does not become complete.

A central scotoma for colours and to a less degree for form is also characteristic of tobacco amblyopia. It is also a fairly common symptom and sometimes a persistent sequela of *acute retro-bulbar neuritis*, an acute inflammatory infection of the optic nerve resembling in its incidence, and probably in its pathology, Bell's paralysis.

In cases of retro-bulbar neuritis the patient, usually a young adult, and most commonly a woman, is affected by a sudden blindness in one eye, without any visible symptoms in the eye itself. The blindness often clears in the course of a few days, and may disappear entirely, or leave, as mentioned above, a persistent scotoma. As a rule after the lapse of a few days a neuritis of varying severity may be observed at the optic disc, and the presumption is that the inflammatory process is situated higher up the nerve and has slowly extended downwards to become ultimately visible at the optic disc. The central scotoma is probably due to the greater liability of the central fibres of the optic nerve to damage owing to the greater distance from the source of their blood supply. (*Vide* supra.)

Constriction of the field of vision.—The exact converse of the central scotoma is often observed, that is to say, the entire peripheral field of vision is destroyed and all that is left is a small central area in the field as represented in Fig. 9. The visual symptoms of this defect are also the exact converse of the central scotoma. Central visual acuity and the ability to read and write are entirely unaffected; but owing to the loss of peripheral vision it is almost impossible for the patient to get about, as he cannot see where

to step and tumbles over things. The difficulty in getting about may be best appreciated if an observer tries to walk about a room with one eye closed, looking down a roll of paper with the other. Though any object which can be seen is seen distinctly, movement and walking are extremely difficult owing to the extremely limited area of vision. With the constriction of the peripheral field also, and with the consequent loss of vision due to the rods, vision becomes extremely defective in dim light; hence night blindness is a constant symptom of extreme constriction of the visual field.

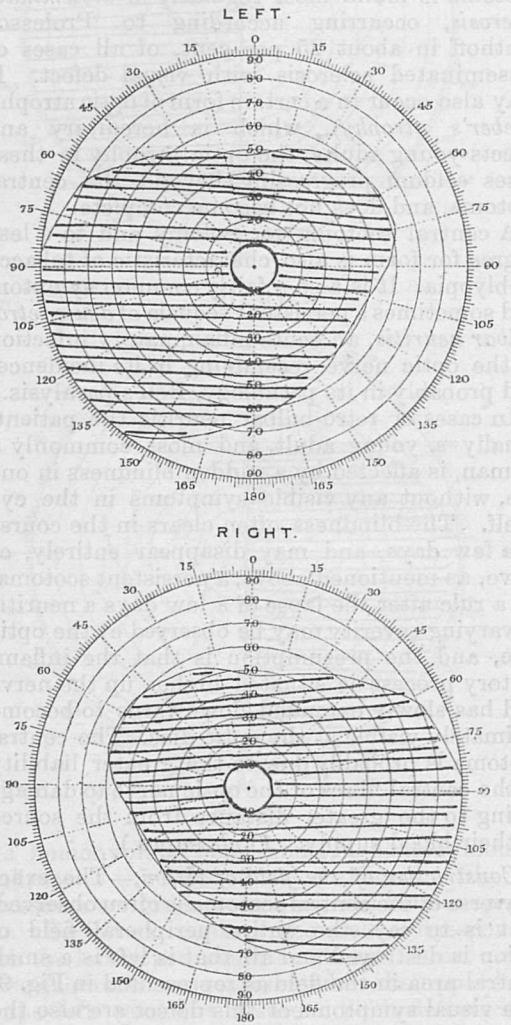


Fig. 9.

Nearly all cases of constriction of the visual field are due to a diminution in the retinal circulation or retinal ischæmia. The type of this field of vision is found in retinitis pigmentosa, a congenital and hereditary disease in which the retinal vessels are extremely small, and in which there is a peripheral disturbance of the pigment epithelium of the retina. It may also occur in quinine amblyopia, the retinal vessels being extremely constricted owing to the action of the drug. In arterio-sclerosis also the retinal circulation may in some cases be greatly diminished, and a similar constriction of the field occur. Fields of this extremely limited type may also occur in glaucoma and optic atrophy, though in the latter they are seldom so small or definite, and the peripheral constriction of the field is usually accompanied with great diminution of the central visual acuity.

The obvious and well-defined affections of the field of vision and their diagnostic significance may therefore be tabulated as follows:—

Visual Defect.	Site of Lesion or Cause of Defect.
1. *Monocular blindness*	In eye itself or between globe and optic chiasm.
2. *Homonymous hemianopia* (hemiopic pupillary reflex present).	In optic tract of side opposite to the blindness between the chiasm and the quadrigeminal bodies (basal).
3. *Homonymous hemianopia* (hemiopic pupillary reflex absent).	In optic tract of side opposite to the blindness, between quadrigeminal bodies and cortex (cortical or subcortical).
4. *Quadrant hemianopia* (always homonymous).	
Superior.	In lower lip of calcarine fissure of side opposite to blindness.
Inferior.	In upper lip of calcarine fissure of side opposite to blindness.
5. *Bilateral temporal hemianopia.*	Chiasm lesion. Pituitary tumour, or internal hydrocephalus.
6. *Central scotoma* (day blindness).	Macular retinal and choroidal lesions. Disseminate sclerosis. Hereditary atrophy. Tobacco amblyopia. Retrobulbar neuritis.
7. *Peripheral constriction* (night blindness).	Retinitis pigmentosa. Quinine amblyopia. Retinal ischæmia. Arterio-sclerosis. Malnutrition. Scurvy. Wasting diseases.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Appointments.

Civil.

Walter Ramsden, M.A., M.D., Ch.B., Oxon, has been appointed to the Johnston Chair of Biochemistry in the University of Liverpool.

Isidore Samuels, L.D.S., has been appointed Dental Surgeon to the West of England Institution for the Blind.

Royal Army Medical Corps.

W. H. Wotton to be temporary Lieutenant, R.A.M.C.

Robert Davies-Colley, M.A., M.C., F.R.C.S., to be temporary Captain.

H. A. Cutler, C. Derwent Pye-Smith, Arnold Leeming, R. J. Hearn and C. Weller to be temporary Lieutenants.

A. L. Anthony to be Lieutenant on probation,

3rd Welsh Field Ambulance (T.)—Major Andrew R. Wilson, from attached to other than Medical Units, to be Lieut-Colonel.

1st Southern General Hospital.—Major J. T. J. Morrison is seconded.

4th London Field Ambulance.—Captain T. B. Layton, from the Unattached List for the Territorial Force, to be Captain (temporary).

2nd London General Hospital.—To be Captain (T.), G. W. Goodhart.

1st East Anglian Field Ambulance.—Captain Lee D. B. Cogan, from attached to other than Medical Units, to be Captain.

North Midland Clearing Hospital.—To be temporary Lieutenant, V. A. P. Costobadie.

To be Lieutenant.—J. F. G. Richards, No. 13 Field Ambulance, 5th Division, 2nd Army, British Expeditionary Force.

Captain G. T. Willan, R.A.M.C. (T.), and Captain W. E. Alston, R.A.M.C. (T.).—82nd Field Ambulance, 27th Division, British Expeditionary Force.

Indian Medical Service.

The King has approved the promotion of the following officers.—Lieutenant C. M. Plumptre, I.M.S., and Lieutenant E. A. Penny, I.M.S., to be Captains.

The services of Lieut.-Colonel S. E. Prall have been placed temporarily at the disposal of the Government of India.

Captain C. H. Reinhold, I.M.S., to Field Ambulance No. 3, Lahore Division, 1st Contingent of Indian Troops.

Civil Department, Punjab. The following officer of the Civil Department of the Punjab has reverted to military duty.—Major H. C. Keates, I.M.S., Civil Surgeon, Multan.

The services of Captain H. Watts, M.B., B.S., M.R.C.S., L.R.C.P., I.M.S., Officiating Civil Surgeon, Betul, are placed at the disposal of the Government of Inda, Army Department, with effect from the date he hands over charge.

Lieut.-Colonel G. T. Birdwood, I.M.S., on being recalled from leave to be Civil Surgeon, Lucknow, and Professor of Midwifery, King George's Medical College, Lucknow.

Naval.

H. W. Eddison to be Probationary Surgeon, R.N.V.R.

H. Rowse Bastard, M.R.C.S., L.R.C.P., has been appointed Temporary Surgeon, R.N., to H.M.S. *Otway*, November 19th.

Staff-Surgeon G. L. Buckeridge to the *Halcyon*.

To be Staff-Surgeon.—Surgeon H. M. Langdale.

To be Temporary Surgeon.—Rolf Creasy to the *Victory* additional for the Royal Naval Division.

To be Temporary Surgeons.—F. C. Broome, G. W. King.

Staff-Surgeon Richard Willan, R.N., H.M.S. *King Edward VII.*

Colonial Medical Service.

Reginald Willan to be Medical Officer with British Forces in West Africa.

Other Units.

R. W. Warrick and A. E. Sawday have joined the French Red Cross.

S. W. Bevis, to be temporary Lieutenant Royal Field Artillery, and has resigned the appointment of Civilian Dental Surgeon, R.N. Barracks, Portsmouth.

H. E. Fox, M.B., to be Lieutenant, attached to other than medical units.

W. G. Hollands, Public Schools Battalion, Middlesex Regiment.

L. U. Ransford, to the 5th Essex Regiment.

Lieut. J. L. Lauder has been reported prisoner of war at "Brüskenoff," Torgan, Germany.

Vignettes from France.

I.

We were sitting close to the bridge over the canal, watching transport, which was taking supplies to the trenches, going across the bridge over the river about a quarter of a mile away. It was about two p.m., and at this time we were not usually troubled by much shelling from the German batteries of heavy artillery concealed in quarries and railway cuttings, but the transport had taken a liberty in crossing the river bridge by daylight. They were seen by some artillery observation post, and soon heavy percussion shells were falling on either side of the road leading to the bridge—raising high columns of black smoke and causing some of the horses to become unmanageable. The shooting, however, was not very good, and the shells dropped over the road on to the field beyond.

After about half a dozen "coveys" of four shells each had been fired, the Germans turned their attention to the bridge which they had so often tried to hit.

They had no more success this afternoon, but they provided the onlookers with a magnificent spectacle,—a couple of shells dropped into the water about a hundred yards from the bridge and raised in succession two large columns of water more than half as high again as some tall poplars which lined the side of the river. It was a momentary but wonderful sight, and will be long remembered by those of us who were lucky enough to see it.

(To be continued.)

BOOKS, ETC., RECEIVED.—The Hospital, Nursing Times, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette, New York State Journal of Medicine.

Letters from Guy's Men on Active Service.

H.M.S. *Defender*,
Destroyer Flotilla,
November 25th.

. . . . Most of the men doing this job went on hospital ships at first, but they had very little to do. I have been on this packet for five weeks now, and though destroyer life is by no means all "beer and skittles," I do not regret having come here, for I have seen as much fun, in fact more, than most people in the Navy.

The work of this war is being done by destroyers, submarines, and light cruisers almost entirely, and we of the 1st Flotilla have done our share all right. I forgot the poor old mine sweepers in the above list of the world's workers; they have the devil of a time—out in all weathers, bobbing along in pairs with their old sweepers out and forming a perfect target for a "monkey." In fact, it is a wonder that more of them have not been "hoffed." I suppose the Germans think they are not worth it. We have been all over the place in the last few weeks, from Dover to Heligoland. We did a little bombarding the other day (see *Daily Mail*, November 25th), and a "nasty" mess there must have been there after we had finished—12 in. shells and shrapnel going off like fireworks. We form a submarine screen on their little shores, and hope for the best.

I don't forget to adjust the little rubber air-collar round my swan-like neck on these occasions! The Admiralty have provided us all with these things now, and I believe they keep one afloat all right and prevent your turning bottom up like the poor devils in cork life-belts we frequently come across on the high seas.

I won't mention any names, but we went the other day to a certain jolly little spot chasing a German submarine. Needless to say we did not find it, and I think someone was "'avin' a gime with us!"

You can guess that my medical duties are not very heavy, though I am in sole charge and do what I like to anyone who is unfortunate enough to fall into my hands. We carry a crew of seventy, and there are, of course, a few sick, who are quickly transferred to our parent ship.

The Admiralty provide us with an excellent surgical outfit—instruments, syringes, and morphia *ad lib.*, catheters, stethoscope, etc., a medicine chest, and some of the more powerful drugs. There is one bottle labelled "purgative pills," containing a powerful concoction, other bottles labelled "cough tablets," "sleeping draught," etc., etc. These have been dispensed promiscuously to fat leading seamen and brawny stokers with no disasterous results so far.

The accommodation is pretty cramped, I sleep in the ward room on a sofa and am pretty comfortable there with my head on the stove like Alfred on the Spray. At sea it is awful and I generally sleep in my clothes. Have you ever been on a destroyer doing 20 knots in a sea way? If not, pray that you never may. I spend a good deal of time on the bridge, and am supposed to take notes for the skipper when we go into action . . . . , Neely is here still. There is a very nice Barts.' man here, on the opposite ship to this, Butcher by name, he knows Broster and some of the Oxford lads at Guy's. I have not seen Parry Price, he is in another flotilla . . . . Yours ever, L. S. F.

Cavalry Field Ambulance,
Expeditionary Force.

Just a few lines to let you know that I am very fit and—except when it rains hard, am enjoying myself very much. Even when it rains I stick two ground sheets round me and the rain then only comes through my hat and trickles down my neck. The last few days have not been quite so warm, in fact they have been beastly cold and rainy. After a fortnight of wet the weather usually clears and part of the day is fine and warm. I have been fairly well up with things since the start. Although, of course, it is not the duty of ambulances to get scuppered, still most of them get shelled occasionally, and I cannot say that I love them, more especially the "Black Maria's," which really are not dangerous except when the ground is very hard, or when they fall on a road. In the ordinary way on a soft field they do not hurt unless one sits right on top of one, and as they throw about 10–14 miles it is very bad luck.

Lots of our people are out here. I have seen Hampton who is in this ambulance, Soothill, Freddy Pern, Pryor, Frank Cook, Sherris, and one or two others. Hampton has seen G. D. Eccles, Philip Smith, Maitland Scott. By the way I hear that Charles Symonds was wounded doing motor dispatch riding—quite a risky game whilst "Williams" are about, but the dispatch riders are doing very good work. I found a smashed motor bike the other day—gears gone—and turned it into a fixed gear, but the owner came along with a motor lorry and I had to give it up.

We have hidden our artillery rather well and they cannot spot it, which annoys them, but amuses our gunner officers enormously. I saw one of our aeroplanes hovering beautifully and directing fire for about half an hour, quite a treat to see it after so many Taubes. Still feeding well.—Ever and ever. H. C. R.

3rd Field Ambulance,
1st Division,
Expeditionary Force.

. . . Have had and am having a very strenous time, was at the Marne and the Aisne for thirty days, and am now in Belgium, so at any rate am seeing some of the country! I suppose you have heard about poor old Hopkins. We've all got to go some day; there is certainly a better chance out here than at home!!

Have had a terrific lot of work, splendid experience though, some quite good surgery; bye-the-bye, I enucleated a man's eye the other day and I thought the

specimen might be of interest to the museum. The small splinter of shell from a "Black Maria" is still fixed into the sclerotic. The same man had an extraordinary piece of luck; a "Black Maria" or "Weary Willie" burst within a few yards of him, and the only effect it had was to make him deaf. A few minutes later another burst quite close, a small splinter of which passed through his upper lid into his eye. I am sending it to you, so you can do what you like with it.

It is Guy Fawkes day, I have seen quite enough bonfires and fireworks to last me a lifetime! Am keeping wonderfully fit and well and have nothing to complain of at all; just had a real bath, the second in two months —have had several washes though. Have every hope of having "a spot of dinner" at the Troc. Grill Room before long.

"Toujours le Bulldog" as the Frenchman says.—Cheery-oh. M. P.

Diagnosis of Gastric Conditions by Chemical Methods.

By J. H. RYFFEL.

Gastric Contents.

A test meal, consisting of about 2 oz. of toast without butter and a pint of tea, is given as the first meal of the day. Small amounts of sugar and milk in the tea do not affect the result, and, as it is important that the patient should have a psychic secretion of gastric juice, they should be added if the patient objects to tea alone. The contents of the stomach are removed from 45 minutes to one hour after the meal by means of an aspirator and measured. The amount usually obtained is from 2 to 3 oz., but may be considerably more or less than this in certain cases. The material is then filtered, the residue on the filter is tested for blood and for bile pigment, and the following determinations are made on the filtrate:

Degree of acidity, i.e., whether acid to Gunzberg's reagent, dimethyl, Congo red, litmus. These reagents are arranged in descending order of the degree of acidity they signify.

Amount of free hydrochloric acid. This is determined by titration with caustic soda using dimethyl indicator. The result is always slightly higher than would be obtained if Gunzberg's reagent were employed, but the procedure is much simpler.

Total acidity is determined by titration with caustic soda, using phenol phthalein as indicator.

Total chloride is determined by adding sodium carbonate till alkaline, evaporating and igniting till charring is complete, and then employing Volhard's method.

Mineral chloride is determined after evaporating and igniting without the addition of sodium carbonate.

Active hydrochloric acid. This is the name given to the difference between the two previous quantities, and represents the free hydrochloric acid together with that combined with protein, amino acids, and other volatile bases such as ammonia, if present.

The results of these determinations are all expressed in terms of grm. of hydrochloric acid per 100 c.c.

If the total acidity so expressed is considerably greater than the active HCl, organic acid is present, and lactic acid can be tested for separately.

The usual figures obtained for normal contents are, roughly: free HCl, 0·10; active HCl, 0·15; mineral HCl, 0·10; acidity =active HCl. The filtrate also normally contains considerable amounts of sugar, proteose, peptone, and pepsin.

Hyperchlorhydria. Only when the active HCl is above 0·20 can definite hyperchlorhydria be said to exist. Figures as high as the following may be obtained: free HCl, 0·25; active 0·36; mineral HCl, 0·12. All cases of gastric and duodenal ulcer have some degree of hyperchlorhydria, unless this is masked by regurgitation, but, as the condition is found in some cases of chronic appendicitis and of intestinal chasis without ulcer and is also found in the gastric crises of locomotor ataxy, hyperchlorhydria must be considered as consistent with and a predisposing cause of ulcer, not diagnostic of ulcer.

Regurgitation from the duodenum. This is evidenced by the presence of bile pigment in the stomach contents and by a raised mineral HCl, the bile salts and alkali of the intestinal fluid reacting with the hydrochloric acid of the stomach to form mineral chlorides. In some cases the condition is obvious, in others the mineral HCl is raised and the contents rather highly coloured without bile pigment being clearly demonstrable. When the condition is well defined it signifies some difficulty in passing contents onwards from the duodenum, perhaps due to duodeno-jejunal kink. An instance where such a kink was found is the following: free HCl, 0·22; active HCl, 0·30; mineral HCl, 0·15; acidity, 0·32; biliverdin easily recognised. Gastrojejunostomy leads to similar results, the pigmentation and the neutralisation of the gastric HCl being generally more marked. Moreover, a similar rise of mineral HCl at the expense of the active HCl is generally seen in normal stomach contents when the stomach is nearly empty. This may be due to regurgitation, but bile pigment is not seen.

Carcinoma ventriculi. Gastric contents have been widely studied in the hope of discovering diagnostic points for carcinoma, but the present position is that, although a diagnosis can often be made from the stomach contents, there is no certain criterion, especially in early cases. Moore, who determined free HCl by the rate of hydrolysis of methyl acetate, contended that the free HCl was diminished in all cases of gas-

tric carcinoma, and of carcinoma anywhere in the body, but exceptions have been found to this generalisation. Graham followed the procedure detailed above, and laid stress on the mineral chloride, contending that, although in the later stages a carcinoma was associated with diminished HCl because carcinoma was not gastric mucous membrane, in the early stages the diminution of gastric HCl was due to an alkaline secretion from the ulcerating carcinoma, which thus raised the mineral HCl at the expense of the active HCl. He found the most useful expression was the ratio of active to mineral HCl, which was only very exceptionally above unity in gastric carcinoma Although this is true in general, there are other causes for a rise in mineral HCl at the expense of active HCl, notably duodenal regurgitation, and the low active HCl found in pernicious anæmia, gastric atrophy, achylia gastrica, etc., may be accompanied by a mineral HCl even as high as 0·15, so that this quantity is not specific. However, the presence of bile pigment in regurgitation and the absence of blood from the contents in the other conditions will generally serve to distinguish from carcinoma. Types of analyses recently obtained at Guy's from cases of gastric carcinoma are shown in the following table:—

Case.	Free HCl.	Active HCl.	Mineral HCl.	Acidity.	Lactic Acid.	Blood.
1	0	·0094	·315	·079	+	++
2	0	·05	·27	·196	++	++
3	0	·079	·137	·115	+	+
4	0	·031	·117	·029	—	—
5	0	·106	·242	·129	—	+
6	·09	·188	·178	·208	—	++
7	·146	·240	·174	·254	—	++

These cases present no one common characteristic. The relation between the active and mineral HCl is in the right direction with the exception of the two cases 6 and 7, where the active HCl is above normal, but here the mineral HCl is very high, higher than is found in other conditions with the exception of marked regurgitation.

No. 4 is the only case in which blood was absent, and in this case blood was present in a later test meal. The presence of blood is clearly an important characteristic of gastric carcinoma, but, although finding blood in the gastric contents is of value as showing where the bleeding is taking place, its presence might conceivably be due to injury with the tube of the aspirator, and blood might be absent on the occasion of the test meal although frequently present, so that more reliable information on this subject is to be obtained from the fæces.

FÆCAL BLOOD.

For the examination about 5 grm. of solid fæces, or more of fluid fæces, are employed. Enough water is added to form a paste, then an equal volume of glacial acetic acid, and finally a volume of ether roughly equal to that of the mixture. The material is thoroughly mixed after each addition, so that a uniform liquid is obtained, from which the ether separates cleanly on the addition of water. A portion of the ethereal extract can then be employed for the guiac, or other similar test, and the rest placed in a test tube about an inch in diameter and examined with with the spectroscope.

When relatively small amounts of blood are sought. the fæces must be free from remnants of meat and substances containing chlorophyll, *i.e.*, the patient's diet must have been free from meat, green vegetables, and coloured fruits for three days, or longer if there is any intestinal stasis. The presence of iron or bismuth does not interfere with the test. Bleeding from the mouth, pharynx, or anus must be excluded.

The spectrum of acid hæmatin in ether is only seen when there has been free bleeding such as may take place from an ulcer.

When free bleeding has taken place some time previously, the remnants of blood still in the fæces may show a broad band in the extreme red similar to that shown by chlorophyll in the fæces, but the extract gives a more marked guiac test than that given by chlorophyll.

Occasionally a positive guiac test is obtained without any absorption band being visible except that of stercobilin, but with relatively small amounts of blood the commonest combination is a positive guiac test and the spectrum of so-called alkaline hæmatoporphyrin, a narrow band being seen in the middle of the red. When this is seen the intensity of the band runs parallel with that of the guiac test. The positive guiac test is not due to hæmatoporphyrin, but to some unknown hæmoglobin derivative associated therewith in the ethereal solution.

When ulceration of a gastric carcinoma has begun, bleeding appears to go on continuously, so that a little altered blood is found in the fæces day after day, the spectrum shown being that of hæmatoporphyrin, with very rarely acid hæmatin as well, when the bleeding is excessive. Slight continuous bleeding appears to favour a more complete disintegration of the hæmoglobin than takes place when the bleeding is more active and intermittent.

During the last two years at Guy's no case of carcinoma ventriculi has been met with, that did not show a positive guiac test and hæmatoporphyrin in the fæces, so that this simple examination should prove a valuable index of the possibility of gastric carcinoma, especially as ulceration, and therefore bleeding, is the more likely to take place when there is still free HCl in the stomach. The spectrum and the persistence of the blood in spite of treatment serve to indicate the possibility of carcinoma of the alimentary canal. The carcinoma can then be confirmed and localised by the various determinations of a test meal in addition to the more general considerations at present available.

Guy's Hospital Maternity Charity.

Herein is presented for your interest and sympathy an account of the work done during 1913 in the cause of the Maternity Charity of Guy's Hospital.

This autumn has brought its own tremendous appeals, and there is danger that quiet and continuous efforts may perforce suffer. Not despite, but because of the European turmoil, a Maternity Charity is of more vital import than ever before, in that it safeguards the new generation, upon whom will depend our continuance as a nation, a nation which must accept as the consequence of war the loss of thousands of its most physically fit.

It is only too true that the majority of births occuring in our district take place under circumstances promising ill for the future serviceableness of the babe to his country. The questions of housing, decent sanitation, and a living wage are involved, and are far, at present, from receiving any adequate settlement.

Our Charity, however, through your kindly help, is able to do much for the individual lives of the mothers and children it assists. Medical aid from the Hospital, the opportunity of obtaining immediate admission of serious cases, daily visits from the nurses, the food, coal and clothing supplied, the visits to convalescent homes arranged, and the reporting to local authorities of instances of rooms, more than usually unfit for habitation, are all important services. They are rendered at a time when the condition of motherhood in poverty craves to the utmost for human help.

It is no small thing that by the nurse's efficient aid perpetual ill health for the mother, or loss of infant life can be prevented. During 1913, 942 new cases were attended by the nurses. 9,406 daily visits were paid. It is very difficult to persuade the poor mothers to leave home after their confinements, there is no one to look after the children, and the man cannot lay out the weekly money to advantage, but 46 of our patients went either to London Mothers' Convalescent Home, Sunningdale, or Beulah Rest Cottage, Sutton; 35 took their babies, and 11 went whose babies had died.

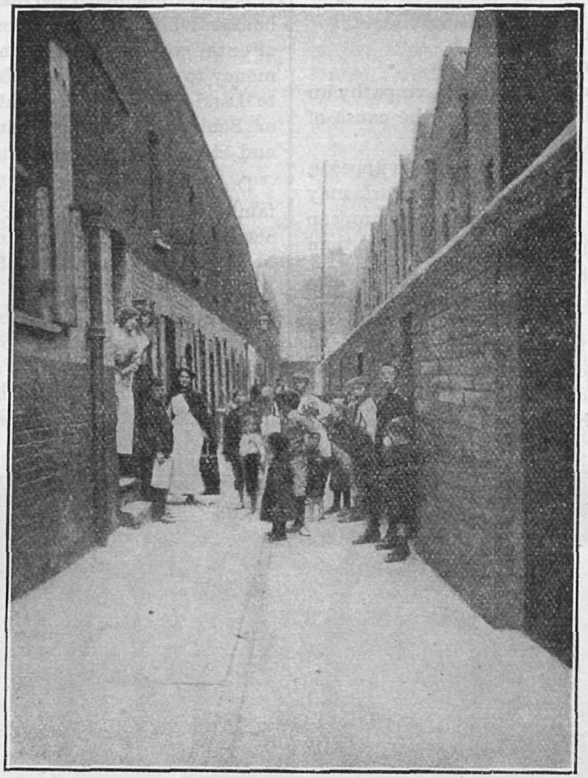
During the year 12½ cwt. coals were provided, and 634 families helped with food. When the nurses are in actual attendance upon the mother, they give her milk or bovril, and pennies are often needed for the gas meter to secure light.

Christmas is a season of great delight for nurses, mothers, and children; 225 families were provided with parcels of clothing, toys, and dolls; 33 families had joints of beef, bread, and half cwt. of coal; 16 families had puddings. Lucky, indeed, is the baby that is born on Christmas Day for a special parcel of clothes awaits it.

The only sad part of the Christmas festivities is the large number who would share in these very simple pleasures, and must be refused. Ill-written and very soiled little letters are received daily giving pathetic reasons why "our Alice aged 11, Bertie 10, George 8, Sarah 7, the twins and the baby," should be added to an already over full list.

On New Year's Day, 1914, we had the great delight of inviting 100 extra children to No. 10, St. Thomas's Street, when Miss Betty Hicks, accompanied by her mother, gave to each child a woolly garment, doll, or toy, and a bun and orange.

Our thanks are due to all who send parcels of clothes, new or old, toys and food. A most acceptable gift was thirty packets of tea from Christ Church, Sutton.



Blankets, pieces of carpet, old rugs and garments of all kinds are most gratefully received and urgently needed.

The Maternity Benefit of £1 10s. assured to the mothers since the passing of the National Health Insurance Act, is, we find, almost invariably used to pay the rent. It is a great relief to the lying-in mother to feel that is secure. In fact, an expectant mother is often able to secure a house or room where previously the very reverse was the case. There is no doubt that this payment is a great boon, but lacking so many of

the essentials of existence your generous help is still required for the poor mothers in our district.

The audited accounts for the year ending December 31st, 1913, show a balance at the Bank of £138. Of this £61 has already been expended during the current year, and our Christmas expenses, including the meat and coal before mentioned, and garments, will be about £37, and we must keep money in hand for the daily necessitous cases.

One of the photographs shows a group of the nurses with their midwifery bags. They are with few exceptions, fully trained Guy's nurses, who come to the Institution for the three months' tuition and practical nursing experience required by the Central Midwives' Board. They are instructed by and work under the supervision of a Resident Coach, a member of the Guy's Trained Nurses' Institution. Last year an assistant was appointed to work with the Coach, and relieve her of alternate night duty.

The other illustrations are of typical dingy alleys visited by our nurses; in the foreground of one is seen the water-tap which serves the whole street, and it must be remembered that in each house there are several families.

Hot water is a great luxury when the water must first be fetched from the street and then warmed over the small handful of coals representing a fire. It is indeed an endless struggle against dirt, which in its turn begets disease.

"Hark! the March wind again of a people is telling;
Of the life that they live there so haggard and grim,
That if we and our love amidst them had been dwelling,
My fondness had faltered, thy beauty grown dim."

In the names of all assisted, and with the thanks of those who have the pleasure of handing on your gifts,

F. A. SHELDON,
Lady Superintendent.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—A resolution was passed at the last general meeting of the Students' Club that you should be requested to publish the enclosed copy of a letter from the Warden of the College for the information of those members who were unable to be present.—I am Sir, yours faithfully,

N. MUTCH.
Hon. Sec. of the Students' Club.

26, St. Thomas's Street,
London Bridge, S.E.,
1st December, 1914.

Dear Sir,—I am to inform you that the College Committee, having carefully considered the Students' Club report on catering sent by you, is of opinion that no change of Caterer is advisable.

The College Committee has appointed a Sub-Committee consisting of Dr. Fawcett and myself, who shall meet the President of the Residents from time to time to discuss any points on catering which may arise.—

Yours faithfully,
L. BROMLEY,
Warden.

The College, Guy's Hospital,
May 29th, 1914.

T. B. Layton, Esq., M.S.,
Hon. Sec. of the Students' Club,
Guy's Hospital.

Nursing News.

Matron's Office.

A long letter has been received by Matron from Miss Paterson (Sister Jentie) from which extracts are given:—

No. 5 Clearing Hospital,
British Expeditionary Force,
21st November, 1914.

I see from the last issue of the Gazette you know I am no longer at Versailles; five of us had a wire to proceed direct to Boulogne. Hearing that the main line was blocked, we decided to go via Rouen and Dieppe, a long way, and we had only provisions for six hours. After difficulties without hand baggage and camp kit we eventually arrived at Rouen at 10 p.m. I sent Scouts for British or French Red Cross people. Eventually Major —— in charge of the British Ambulance Train Department arrived with two Red Cross helpers, and we had a hot supper! The station was full of arriving and departing troops, but all refreshment places were shut.

The Major told us how he had worked up the trains from the cattle trucks, as we saw them first in August, to waggon lits on corridor trains. We left at 11 and reached Dieppe at 3 a.m., but I got permission from the station master to remain in the train until it returned at 5.30. We walked about until 6.30, when the hotels opened. We were rewarded by a splendid wash and a breakfast, and a fly round to see the English boat off, and then on again, after many halts and changes, reaching Boulogne at 6 p.m.

We reported ourselves to headquarters, and great was our joy to find that we were asked to go forward to a clearing hospital. General —— had been impressed with the need of Sisters, and had asked for them. There was at first the idea that we should be an added responsibility and have tons of baggage! Now they say they would not part with us. We stayed four days at Boulogne; glorious sunshine like September, not November. The large hotels along the front are all hospitals or billets for Sisters. The Casino is also a hospital—all British, no French. The streets are full of motor ambulances. Fortunately, Kitchener arrived when we were here. The work was abnormal, and one never felt you had done anything.

As it was only for four days, I refused to take over a corridor, but helped with dressings and specialed several cases. The great drawback was the cases came in and went out so quickly we could not keep pace with the work on base hospital lines, but we did our best. I know two mouth cases were the better for my efforts.

The food and discomforts at Boulogne were the worst we have so far encountered. Here we have

splendid billets. When the orders came to proceed here we got some provisions, and eventually found a train in which we sat for five hours before it started.

This hospital is a monastery. We nurse principally in the refectory where we have 4 rows of stretchers, 100 in all. We are on the road side and see every one and thing pass. Last week a Glasgow Territorial Regiment went by. I knew many officers and also many recruits in the ranks. I heard the pipes, sent an orderly to see what regiment, then flew to the door —I am on the ground floor. I heard a yell and saw several hands waving. Later I paid a state visit to the mess; those I did not know personally knew father. Some I left in August on the golf course!

We had a great excitement the other evening. A Zeppelin came over and left a bomb—in all, eight bombs were dropped all around the hospital. No buildings were actually struck, but odd bricks were dislodged, and one man was blown to pieces, and two injured. One bomb fell on a field opposite where troops had camped for several days and only left a few hours before. Sometimes we hear the roar so distinctly of the shells here that the windows tremble and our rest is disturbed.

Some days here we are frightfully rushed, others little to do. I like the work immensely, and though I liked my ward at Versailles, I never want to work in a general hospital again. I believe we are definitely attached here, so hope to proceed soon. We are supposed to move at two hours' notice.

Arrival of convoy; all orderlies assemble; stretcher cases or badly wounded "sitters" come to us at once; emergencies seen at once all fed and allowed to sleep; then dressed, and we try to wash at least hands, face, and feet, and change socks. Sometimes so many come in and go out in four hours we cannot do more. When they stay the night we can get in a full washing, clean shirts, and exchange old clothes.

We keep amputations two or three days and generally have several bad cases left when the rest of the convoy goes off. One day we had three different convoys in and out, and kept the fourth for the night. In that case we have to hop around smartly.

Miss Lyms (late Sister Mary) was booked for another clearing hospital, but so far is still at Boulogne. The hospital next to us, a few miles up, demolished by bombs yesterday; we got their patients until the train came in.

Midnight; hands frozen; no time to re-read; remembrances to all friends.

Writing to the Institution, Nurse Gwilliam, who is working for the British Red Cross, says:—

We only stayed four days at Boulogne after leaving Biarritz, when we received an urgent call to Calais. Twenty-two of us arrived in motor ambulances post haste. Here there was absolutely no accommodation for the wounded at all; we had 20 beds for them and hardly a cup to give the poor things a drink. Finally we obtained this building which is a large girls' college and really makes an excellent hospital. We are getting quite smart. We have 7 wards and about 150 beds. Nice little iron bedsteads and red blankets which look so cheerful with the red bed-jackets. Our doctors' tables, *linen cupboards,* etc., are composed of packing cases, but we find it is wonderful what one can do with a packing case, a plank, and a sheet to drape with. Now we are getting a good supply of basins and jugs, also we have had gas rings fitted up for the sterilizers, so we feel very well equipped. We have two nice little theatres, also a radiograph room. There are five Red Cross doctors and two St. John's, and the other day about 20 orderlies were sent out, but they are not trained, so they do none of the nursing like the army orderlies at Boulogne did. Most of them are clerks from various places like the Prudential, and it is funny to see them trying to scrub the floors. All our stores come from England; you can buy nothing in Calais; in fact, we could not even get milk, so we had 2 cows sent out. The Calais people object to have the Belgians here at all. Oh, I don't think I told you we only have Belgians here, just one or two French, and very rarely an Englishman, and at first they would not sell us any food. Some of the good ladies of the town used to bring great jugs of soup for the poor men; it was really dreadful until we could get our own stores.

We only have one side of this college, the French have the other They have the front of the building, we have the back. We have a huge mess-room downstairs; we all have meals together, and now we have two excellent army cooks. To-day we have sent out about 60 patients to England. You would laugh if you could see our dormitory. There are 22 of us in it, and only one basin for washing, but we are really very luxurious now that we have beds to sleep in; the floor with only your rug was very hard.

We are expecting a fresh supply of wounded any moment now the Belgians are back in the first line. They have been resting just lately. This afternoon, as so many were going out, two of us had the afternoon off duty, and when we arrived back we found three of our patients left. So we spent the evening spring cleaning the beds and the ward generally, and it does look so nice with the fresh sheets and covers. The other day I was presented with a fern, so, you see, we are getting more like a London hospital every day.

We started another house for enteric on Friday, and before the beds were put up, 6 patients arrived, 7 more in the night, and 9 the next day; to-day they had to refuse 6. I'm afraid there will be a lot more soon. Major —— has been promised a boat in three weeks' time, but what we shall do in the meantime I don't know; he has gone to England to try and get a boat at once.

Birth.

SEYMOUR PRICE.—On November 27th, at 57, Sloane Gardens, S.W., the wife of Lieut. P. Seymour Price, R.A.M.C.T., of a son.

Marriages.

BASTARD—OVERELL.—H. Rowse Bastard, M.R.C.S., L.R.C.P., second son of Mr. and Mrs. S. W. Bastard, of Iresmarrow, Launceston, Cornwall, to Chérie, elder daughter of Mr. and Mrs. W. J. Overell, Brisbane, Queensland, at St. Tudy, Cornwall, on November 21st.

LYON—MOWFUNG-CHUNG.—At All Saints' Church, Tientsin, on 15th October, 1914, by the Rev. J. R. Sedgewick, Bayard Lyon, eldest son of Judge Jay F. Lyon, Elkhorn, Wisconsin, to Elsie, second youngest daughter of the late Mr. Mowfung Chung, of Hongkong and Australia.

Death.

CAZENOVE.—On November 18th, William Reginald Cazenove, M.R.C.S., L.R.C.P., of West Norwood Lodge, Knight's Hill, London, aged 40 years.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Hearty Christmas Wishes to all Guy's Men & Nurses Abroad!

Passim.

Colonel Lord Goschen helps to carry the big drum during a recruiting march in Kent. He is covering nearly 200 miles on foot.

WE are indebted to the *Central Press* for the photograph of our Treasurer, The Right Honourable Viscount Goschen, reproduced above. Colonel Lord Goschen commands the 5th Buffs, and recently went on a recruiting march in the Weald of Kent and Romney, covering on foot nearly 200 miles.

His Lordship took his turn with the other officers in carrying the big drum, to give the drummer a rest. The vigorous manner in which Lord Goschen beat the drum was much appreciated during the long marches.

Our Treasurer returned to the Hospital last week, looking very fit, and eager to continue the great work he is doing for Guy's.

May he long continue to give us the benefit of his knowledge and experience; although Charity already owes a debt to him which can never be repaid.

IT is our duty and a pleasure to wish everyone who is or has been connected with Guy's, a Happy Christmas and a Happier and Brighter New Year.

This Christmas is new to our experience; we cannot look forward to a Merry Yuletide, and it would be very unappropriate to celebrate the coming of the New Year by dancing round a bonfire in the Court-yard, which is our customary homage to Time.

Time speeds away—away—away;
Another hour—another day—
Another month—another year—
Drop from us like the leaflets sear;
Drop like the life-blood from our hearts;
The rose-bloom from the cheek departs,
The tresses from the temples fall,
The eye grows dim and strange to all.

In former years we have chronicled a long list of entertainments, schemes of ward decoration, and, other outward signs of our worship of this old established custom, sanctified by Religion, and, so dear to our hearts.

Do not imagine that the Residents have been idle; despite the call of extra work, the Niggers have reached a high state of proficiency, and, will go their usual round on Christmas Day. The hard worked but energetic President of the Residents, Mr. E. D. Scott, has organized two concerts to be held in the Physiological Theatre on Monday the 28th, and Tuesday the 29th of December, respectively, at 8 p.m.

Nor have the children, for whom Christmas must always be a time of Carnival, been forgotten. The Out-Patients' Tea and Concert will brighten the lives of the Borough little ones' for at least one day, and, we know that Santa Claus will not forget the children in the Wards.

The absence of elaborate decorations is a matter of small consequence, and, although we regret that many artistes who have so generously entertained the patients in former years will not be with us, we venture to predict that the informal concerts to be held in the wards will be voted a success by all.

This Christmas must for many of us be one of sentimental abstraction. The Bells and Carols will awaken happy memories of the past, and, even if the memories of the present be sad, they will fill us with emotion; and, after all, although the stolidity of English Character despises effusiveness, Emotion and Sentiment are the tenderest possessions of the human mind. No matter then if some of the external symbols of Christmas are missing; for our heroes abroad the present is a time of self-sacrifice, of absence from home, a struggle for our existence; for us it is a time of struggle with disease. Yes, Christmas without decorations is possible, but, Christmas without self-denial and generosity, the emblems of all that is best in our home training, the central part of our family existence, Never!

Our readers will be interested in the account of the Glastonbury Thorn which Mr. A. W. Down has very kindly sent to us. This variety of hawthorn, flowering about Christmas, is said to have been introduced by the monks of Glastonbury Abbey, now a ruin, in Somersetshire. It is interesting that this thorn should still retain this Eastern habit after 2,000 years. Can anyone enlighten us further on this subject?

"You expressed some interest in the fact that I have in my garden at Thornton Heath an offshoot of the original Glastonbury Thorn, which was last year in full bloom on Christmas Day; at the present time (November 15th) it is in full leaf, while many other thorns in the immediate neighbourhood are entirely bare.

The following crude verses were written down for me by my father (Dr. George Down) many years ago. He was born in Somersetshire in 1819, and told me that he had heard them so frequently from rustics, many of whom could neither read nor write, that he could say them by heart when only 9 or 10 years of age:—"

Legend of Glastonbury.

"Who hath not heard of Avalon?
'Twas talked of much and long agon:—
The wonders of the Holy Thorn,
The which soon âter Christ was born,
Here a planted war by Arimathê
Thic Joseph that com'd our the sea
And planted Christianity,
Thâ zà that when a landed vust,
(Zich plazen wâr in God's own trust)
A stuck his staff into the groun
And o'er his shoulder lookin roun,
Whatever mid his lot bevâll,
He cried aloud now 'weary all!'
The staff het budded and het grew,
And at Christmas bloomed the whole day droo,
And still het blooms at Christmas bright,
But best thâ zâ at dork midnight,
A pruf o'this if pruf you will,
Is voun in name o' Weary all Hill!
Let tell Pom parles or lazy Brue
That what is told is vor sartain troo!"

A. W. D.

Captain Malcolm Leckie has been awarded the Distinguished Service Order "For gallant conduct and exceptional devotion to duty in attending to the wounded at Frameries, where he was himself wounded."

We are pleased to say that the report of his death is only a rumour, and the gallant officer's family are not without hope that the rumour is untrue. Guy's! You are proud of such sons!!

Owing to the fact that after Christmas there may be a further decrease in the number of House Officers; a new scheme has been formulated so that all appointments shall commence on February 1st. By these arrangements men who qualify in January will be eligible for these posts. There are vacancies for one House-Physician, two House-Surgeons, four Out-Patient Officers, four Assistant House-Surgeons, one Ophthalmic House-Surgeon, and six Clinicals. Applications to be sent in before January 23rd, 1915. To make this possible the Out-Patient Officers will be asked to continue their present duties until the middle of January, and to forego part of their usual month's holiday. We know that they will do this quite willingly.

The Assistant House-Surgeons will take over the duties of the Out-Patients' Officers about the middle of January. A Surgical Out-Patient Officer will be appointed for one month to do the Out-Patients' duties of the Assistant House-Surgeons until the new appointments are made at the end of January.

The following are the proposed new arrangements of Clinical Ward during war time:—

1. Clinical Wards to be assigned to the two Physicians of Stephen Ward—Dr. Fawcett and Dr. Beddard—the beds, male and female, being equally divided between them.

2. Six Clinicals to be appointed for three months—two to the two Senior Physicians, and one to each of the others. The Clinicals each to have four beds in each Male and Female Ward under his direct care exactly as at present in the Clinical Wards, and to be allowed week by week in rotation to select from cases about to be admitted into the Hospital such cases as they may desire to have treated in their own beds. The Clinicals, so far as not otherwise occupied, to discharge the duties at present performed by the Ward Clinicals.

3. The beds in the Isolation Wards to be under the care of the Physician to whom the Clinical in charge of the patient is attached, and the Clinical for the week to be responsible for the patients admitted to those Wards during his Take-In week.

The Staff must have been very reluctant to make any alterations in the time-honoured post of "Clinical," a unique appointment which has no counterpart in any other hospital, and one which trains men to gradually assume all the responsibilities of the qualified practitioner.

The only disadvantage in the new arrangements is that the Clinicals will miss the *room* in which it has been the custom to have tea, perform blood-counts, *write reports*, etc.; above all, they will miss that informal discussion of their cases with the physician which is so valuable a feature. The fact that apparatus is rather scattered will not prevent the keen men from pursuing their researches. Perhaps an effort will be made to avoid these difficulties.

The Staff, most of whom were "Clinicals" in the past, will, for reasons of sentiment as well as policy, be anxious to revert to the old order of things as soon as opportunity arises.

GUY'S HOSPITAL.

Resident Appointments and the War.

The Medical and Surgical Staff of Guy's Hospital, having learned that the Governors have approved their proposals for rearranging certain appointments in the Wards in order to meet the conditions caused by the War, think it may be useful to explain to Guy's Students and recently qualified Guy's men the objects they have had in view in framing their recommendations.

It is recognised that the War has created a great demand for the services of medical men both at the front and in the training camps. At the same time there is for most men a strong desire to render direct service in a naval or military capacity, and thus the number of applicants for civil hospital appointments is lessened. The first requirement seems, therefore, to be to diminish the number of appointments without impairing the efficiency of the Hospital in its work whether in treating disease or in training its Students.

Whilst such a step will entail considerably increased work upon the members of the diminished Resident Staff, it is felt that this will be regarded as desirable, since men will be more satisfied to remain on civil duty, if working at high pressure, and thus constantly reminded of the indispensable character of their services.

A re-arrangement providing a diminished number of appointments each entailing added work and responsibility having been secured, the Staff confidently appeal to recently qualified men to assist them in carrying on the Hospital by coming forward to fill these posts. The nation looks to the medical profession, not only to provide all necessary professional assistance for the men in the fighting line, but also to enable them to give these men the assurance that their dependents at home shall be well looked after during sickness. The work of bringing forward a constant supply of newly qualified men by the Medical Schools is a duty which cannot be interrupted. The Staff would be unable to take their proper share in meeting these professional responsibilities without a continuance of the help which is to-day being so loyally given to them by the Resident Officers.

Junior Students.

To Unqualified Students, whose help in carrying on the work of the Hospital is equally essential, the Staff would also make an appeal that they should consider very seriously before taking any step which will postpone the date of their qualification as practitioners.

Any considerable prolongation of the war will make the need for additional medical men very insistent, and it is probable that those who have already commenced the study of medicine cannot render any more useful national service than by preparing themselves as speedily as possible for the responsibilities of medical praictice.

Re-Arrangement of Clinical.

The diminution in the number of House-Physicians and the use of Stephen Ward for wounded Officers have made it necessary to re-arrange the beds allocated to Clinical Assistants and to distribute them partly in Clinical and partly in the General Wards. The status and the duties of the appointment will, however, remain the same as those of the present Clinical Assistants in Clinical Ward, and the holding of the appointment, whether before or after qualification, will be regarded as a very valuable, if not indispensable, preparation for the responsibilities of Out-Patient Officer and Resident Appointments.

Signed on behalf of the Medical and Surgical Staff,

W. HALE WHITE, Senior Physician.
W. ARBUTHNOT LANE, Senior Surgeon.
H. C. CAMERON, Dean.

We hope that men will make a loyal response to this letter from the Staff. Further experience has confirmed the opinions published in the Gazette at the beginning of the war, and we do not propose to labour them further.

Why not draw lots to decide who shall stay here?

The public are now beginning to view the shortage of doctors and students at home with great anxiety. Let the Medical Profession itself solve the difficulty and thereby avoid Government measures.

In a letter to the president of the General Medical Council with regard to the duty of medical students at this juncture, Surgeon-general Sir Alfred Keogh says:—

"I think, with you, that the senior student is best fulfilling his duty to the country by getting his degree, and then joining the Army. The need for young qualified men will become great, and I should regret that the supply should be diminished."

Medical Students and the War.

1. There has been much misunderstanding as to what is the duty of Students of Medicine in war time, especially in the present state of affairs.

2. There can be no question that the duty of a student is to go on earnestly with the work of his profession in order to become qualified as soon as possible, and to offer his services to the country as a medical officer in due course.

3. The rushing of numbers of students to enlist as Privates in the R.A.M.C., in the various hospitals and other units, has landed them in a quite false position.

4. On representation of this to the Director-General he fully recognized the position, and he gave the necessary authority to liberate from the First London General Hospital all those who wished to return to their proper medical studies.

5. I need scarcely say that it takes vastly longer to make a Medical Officer than it does to make even a competent Combatant Officer, and for that reason a Medical Officer is by so much the more valuable in the service of his country.

6. No man can tell how long this war may last, but in any event there can be no doubt that Medical Officers will be required for new battalions to an unknown extent in the future.

7. Those Students who are yet some way from their final examination should not allow themselves to be led away by enthusiasm into a position which renders professional study impossible. They are advised strongly to go on with their work and to join, as many are doing, the Section of the Medical Unit of the University of London Officers' Training Corps to which their Hospital belongs, in order to gain a knowledge of the Military side of a Medical Officer's training, which will be of the greatest value to them in obtaining Commissions, and after.

(Signed) HOWARD H. TOOTH,
Lt.-Col. R.A.M.C., T.,
O.C. Medical Unit,
University of London, O.T.C.

We note with pleasure that the following Guy's men have been given grants by the National Medical Research Committee:—

Dr. H. Corry Mann, who is to investigate the clinical and sociological problems connected with rickets. This is a subject to which Dr. Mann has devoted a vast amount of careful work, as all men who have had the opportunity of seeing his complete case records know.

Dr. P. P. Laidlaw, assisted by Mr. Finnemore: The chemical relations of iodine to the secretion of the thyroid gland.

Dr. Boycott: Chemical influences upon bacilli.

Dr. Leathes will work upon the relation of fat metabolism to rickets.

It will interest Guy's men to hear that Mr. Stewart Cresswell, of Dowlais, and Dr. F. D. S. Davies, of Cardiff, leave this week for Berck-sur-Mer as Medical Officers to the "Glamorgan and Monmouthshire Hospital for French Wounded." Dr. Herbert Cook, of Cardiff, is to be Surgeon-in-Charge.

They are taking eight hospital nurses, a housekeeper, two dressers, ten orderlies (one of whom is an electrician and two are carpenters), and one hundred beds; and will be located in a large hotel. The funds collected by private subscription will suffice to run the hospital for six months. A lady has given a complete X-ray equipment.

May we bring to your notice a letter in our correspondence columns, making an appeal for funds to provide an X-ray apparatus for a Belgian Hospital? The sum required is very small, and we feel sure that, with the generous help of our readers, it will soon be collected. The Gazette will be very grateful to receive donations for this deserving cause.

Dr. G. N. Bartlett has been appointed Medical Superintendent of the Exeter City Asylum. Dr. Bartlett had been previously at Bexley Asylum, and is at present Assistant Medical Officer of the London County Asylnm at Horton, Epsom. The Medical Superintendent will also act as Consultant upon mental cases occurring in the City of Exeter.

We read in the *Peking Gazette* that Miss Edith Haward has been appointed Matron of the new Men's Hospital of the Union Medical College, Peking. Miss Haward was trained at Guy's; she entered the Hospital in 1908, and left in 1913. We offer her our hearty congratulations.

The site of the new Hospital was given by Mr. George Oliver Jones, M.A., of Liverpool, and among the largest donations towards its construction were sums of £2,300 and £2,500 from the China Emergency Committee and the Arthington Trustees respectively.

Dr. Wenham, the present Medical Superintendent, did much to render the building of the Hospital possible by his energetic campaign for funds in England.

With characteristic energy and foresight, Major T. B. Layton has sent a detachment of orderlies from the 4th London Field Unit, 2nd London Division R.A.M.C. (T.), to receive practical instruction at the Hospital. The men show great kneenness and have made themselves useful in the Wards and Out-Patient Departments. They appreciate the work and are doing it right well, we offer them a very hearty welcome.

Mr. Newland-Pedley, Consulting Dental Surgeon to No, 2 Red Cross Hospital, Rouen, has written a long letter to the Dental Department in which he states that he is doing the dental work of the Red Cross Hospitals, the General Hospitals, the Convalescent Camp, and the Motor Transport Depôt. The latter alone has 1,500 men.

He says that on the average every soldier requires several fillings, and at least 10 per cent. require artificial teeth. He leaves us to calculate how many fillings will be required when the new army of one or two millions arrives. A Dental Corps is wanted.

Mr. R. Clement Lucas was operated on in Bright ward for appendicitis last week. We wish him a speedy return to health.

Our correspondence column has not been forgotten this week. There is a complaint regarding nurses' veils. This does not apply to our own nurses who wear a most neat and business like uniform without any superfluous decoration. After a most careful enquiry we find that the only mishap on record happened to a nurse who was in out-door attire. Unfortunately her veil flapped in the wind and entwined itself round a gentleman's neck. As a Sister, who shall be nameless, remarked "Luckily, he was a gentleman!"

Another correspondent deals with cases of diabetes occuring in several members of the same family. Such records are most instructive, and we ask our readers to give more support to our correspondence columns than has been the custom in the past.

True Tale with a Moral.

A Red Cross Pupil saying farewell to a Theatre Sister.

R.C.P.—"Thank you *so* much for all you have taught me. I have learnt *all* I want to know in three weeks."

Sister (smiling).—"And what are you going to do?"

R.C.P.—"Oh! I am going to start a hospital of my own and run it myself."

Sister.—"And have you a theatre?"

R.C.P.—"Oh, no! But I have a mortuary which I am going to use as a theatre when required." *St. Thomas's Hospital Gazette.*

Belgian Wounded.

"'Qualified men and dressers are urgently wanted to go down by special train to Folkestone this evening to deal with four thousand Belgian wounded who have arrived from Ostend.' This message was delivered at 8.45 p.m. on the evening of October 18th, and, after a hurried call for volunteers, a party of twelve, including residents and dressers, left Guy's Hospital (London Bridge S.E.), at 9.20 p.m., for Charing Cross. It was with a tense thrill of expectancy that they moved off through the station between lines of eager and silent spectators to the well-equipped hospital train placed at their disposal by the military authorities, and proceeded without further delay to their all-important work. Guy's also has received wounded officers for treatment, and is altogether doing its best to be thoroughly helpful at this critical time. The financial side of the question is of course giving grave anxiety to all concerned, but they are sufficiently optimistic to trust that their old friends will not forget their hospital's very urgent need."

Our Hospitals and Charities Illustrated,
December, 1914.

Medical Research Committee.

RESEARCH SCHEMES.

Bacteriological problems.—Morphology of bacillns. Cultural investigations. Virulence and attenuation. Mutation of type of bacillus. Chemical influences upon bacilli. Manchester: Prof. Boycott (whole time £250).

Rickets.—Investigations of the common deficiency factor in diets of children who develop rickets. Systematization of hospital dietetic records. Relative efficiences of curative diets. London: Dr. Corry Mann (Evelina Hospital) £300.

Thyroid secretion.—Chemical relations of iodine to the secretion. London: Guy's Hospital, Dr. P. P. Laidlaw £50, assisted by Mr. Finnemore £50.

Papers by Guy's Men.

H. W. Barber, M.A., M.B., M.R.C.P.: Urticaria pupulosa.—*Practitioner*, December, 1914.

E. W. Goodall, M.D.: The war and typhoid fever.—*British Medical Journal*, 5th December, 1914.

Sir James F. Goodhart, Bart., LL.D., M.D., F.R.C.P.: The injection treatment for hæmorrhoids.—*Practitioner*, December, 1914.

W. Sampson Handley, M.S., F.R.C.S.: A legally established case of traumatic carinoma of the breast.—*Ibid.*

C. E. Iredell, M.D., M.R.C.P.: A case of leprosy treated with radium and diathermy.—*Lancet*, 5th December, 1914.

Change of Address.

Temp. Lieut. A. N. Leeming, R.A.M.C., Officers Mess, 6th Oxford and Bucks Light Infantry, Blackdown, near Farnborough.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Books, etc., Received.—Transactions of the London Dermatological Society, The Prescriber, Bulletins 95 and 96 of the United States Public Health Department, Dublin Journal of Medical Science, M.S. Journal, Hospital, Nursing Times, St. Bartholomew's Hospital Journal.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

A Case of Acute Yellow Atrophy of the Liver.

Amelia F., æt. 52, was admitted into Mary, November 6th, 1914, under Dr. Shaw, for "jaundice."

Personal History.—Patient was a married woman with ten children, all of whom were healthy, the youngest being 14 years old. She had one miscarriage nine years ago, and had reached the menopause two or three years later.

Previous Diseases of no importance.

History of Present Disease.—Six weeks previous to admission patient complained of headache, general malaise, and anorexia. Three weeks later she noticed her eyes were becoming yellow. This pigmentation gradually became more marked, spreading over the skin of the body, and was accompanied by attacks of vomiting with alternate constipation and diarrhœa.

Condition on Admission.—Temperature, 98·4°; pulse, 100; respirations, 24. Patient was a well-covered woman whose entire skin was deeply pigmented with yellow. She lay comfortably in bed, was quite cheerful, her condition mentally was good, and she only complained of headache, anorexia, and of her mouth being full of mucous saliva.

Alimentary System.—Tongue moist and slightly furred, teeth, fairly good, tonsils, fauces, and buccal cavity healthy. The abdominal wall was fat, the abdomen protuberant and supple. On palpation the liver and spleen were hard, the liver extending down a quarter of an inch below the inferior costal margin of the right chest in the mid-clavicular line and also into the epigastrium.

Cardio-vascular System.—No abnormality present.

Respiratory System.—No abnormality present.

Central Nervous System.—Pupils equal, reacted to light and accommodation, knee-jerks absent, and the plantar reflex very slightly flexor.

Genito-urinary System.—Kidneys impalpable.

Urine.—Colour, bright yellowish-brown, staining the specimen glass; reaction, acid; sp. gr., 1015; albumin, trace present; pus, blood, absent; bile pigment present in quantity.

Progress of the Case.—Patient became gradually more deeply jaundiced over the whole body, her headache more acute, and she got more and more drowsy every day, and was treated for acute catarrhal jaundice. On November 9th she complained of a general feeling of "heaviness," and was attacked with slight vomiting in the morning, the vomit being very mucous in character. A purge was given on the previous night and her bowels were open three times during the day, this being the first time they were open since admission. The fæces were examined and found to be perfectly normal. Patient's condition gradually got worse, and on November 15th she was very drowsy and cried out now and again. On November 16th her temperature, which had constantly kept above normal since the 9th, suddenly fell to 97·6°. A purpuric rash was noticed on the outer side of her right thigh and on both upper arms and axillæ. Patient fell into a state of coma, and incontinence of fæces and urine followed. On November 17th the state of coma persisted and patient became dyspnœic. The liver was now impalpable, except in the epigastric region, and the area of liver dulness had markedly diminished; the plantar reflex was now extensor. On the condition of the liver and the general condition of the patient, Dr. Hertz diagnosed "acute yellow atrophy of the liver." Patient's condition rapidly became more critical, the mucous secretion in her mouth was now of a greenish yellow colour, and finally almost black, and very offensive. On November 19th there was a sudden rise of temperature to 104°, coma persisted accompanied with extreme dyspnœa, and patient died at 4 p.m.

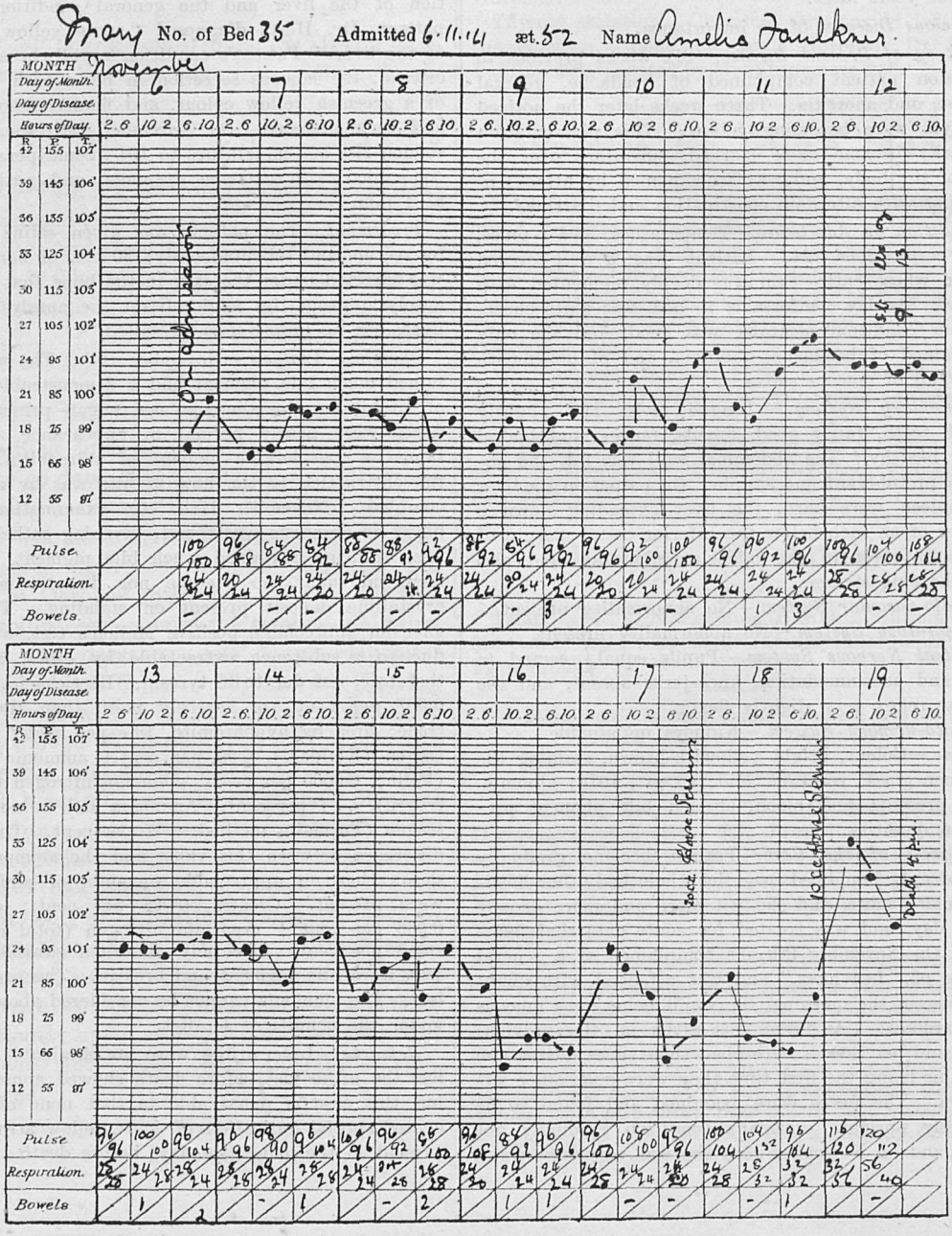
Treatment.—The patient was given saline solution by rectum and subcutaneously; 30 c.c. of horse serum was injected under the skin in the hope that its anti-autolytic properties might arrest the autolysis in the liver, but no improvement resulted.

Chemical Analysis.—November 10th. The urine contained much bile pigment and a demonstrable amount of urobilin. No albumen nor sugar present. The fæces were nearly normal in appearance and contained a considerable amount of stercobilin. Hence the obstruction to the flow of bile was by no means complete. November 17th: On examination of the blood no organism was found. Evening catheter specimen of urine contained much bile pigment, no albumen, no sugar, no acetone nor diacetic acid. No crystalline deposit present on standing. The urine gave an appreciable positive Mellon's test, which was due to a substance extractable by ether, and was, therefore, not due to to tyrosin. Lactic acid, roughly, 0·007 per cent., or scarcely more than the normal trace; urea by hypobromite, 1·87 per cent.; total nitrogen (Kjeldahl), 0·96 per cent.; ammonia nitrogen (Folin), 0·0665 per cent.; ammonia nitrogen (total nitrogen), = 7 per cent. Ammonia and amino acid nitrogen (Formalin method, 0·07 per cent. The minute difference between this value and the ammonia value shows that no appreciable amounts of amino acids were present. Creatin, 0·028 per cent.; creatinin, 0·086 per cent.; creatinin nitrogen (total nitrogen), =3·3 per cent. The only abnormal substances present were bile pigment and creatin. The creatinin is low. The ammonia cannot be considered above normal under the conditions of diet.

Remarks.—Later urines were not obtainable. Doubtless the urine just before death showed abnormalities, but this case is remarkable in that none of the accepted special indications of acute yellow atrophy were present in the urine two days before death

Post-mortem Report, No. 626.—The body was that of a well-nourished woman; there was no anasarca. The vitreous, especially the lens and cornea, were slightly yellow in colour. There were no pleuritic adhesions nor signs of recent pleurisy. Both lower lobes of the lungs were congested and somewhat œdematous; in the posterior margin of the left lower lobe there was a strip of collapsed lung, which was airless and sank in water. There was no healed phthisis. The pericardium was slightly jaundiced; there was no evidence of old or recent pericarditis. The heart weighed 298 gms.; there was no hypertrophy nor dilatation; the muscle was soft, but otherwise healthy; there was some senile atheroma of the mitral valve, the other valves were normal. The aorta was rather atheromatous, particularly the abdominal portion.

The cut abdominal wall presented a large localised area of intra-muscular hæmorrhage, about five inches by three inches in extent, stretching diagonally from the right side above the umbilicus to an equal distance



below the umbilicus in the mid line. The stomach and intestines looked natural. There were about 10 oz. of clear fluid in the abdomen. The liver was small, weighing only 1,098 gms., and felt soft in consistence; externally it was of a dark green colour, and the capsule was somewhat wrinkled. On section the liver, as a whole, was of a brilliant canary-yellow colour, and the outlines of its structure could not be distinguished; scattered throughout the liver, however, were irregular, darker areas, varying in size from a quarter to two inches in extent; these areas were of a deep, reddish-brown colour and apparently had undergone less change than the remainder of the organ.

The gall-bladder was quite healthy, and no calculi were found in any part of the biliary passages. A small amount of bile was present in the gall-bladder; this was quite fluid and flowed easily into the intestine. The pancreas and lymphatic glands were normal. The spleen weighed 208 gms., and its capsule was irregularly thickened.

The kidneys, together, weighed 430 gms.; there was no "gaping" where the capsule was split; the capsule stripped easily, leaving a smooth surface on which were seen a few stellate veins. The organs, as a whole, were dark-green in colour, but were somewhat mottled, with dark hæmorrhagic points both internally and externally. The outlines were rather obscured, but cortex and medulla seemed to bear the normal relation to each other as regards size; the vessels were not thickened.

There was no pregnancy, and the vagina, uterus, ovaries, and fallopean tubes appeared healthy.

Examination from a culture of the liver substance proved the presence of the bacillus coli communis and the streptococcus longus.

Morbid Histology.—Portions of the liver and kidney were fixed in formalin, and sections cut with a freezing microtome. It is evident from the appearance of the sections of the liver that massive necrosis of the liver cells has occurred, and all stages from the beginning of necrosis to complete disappearance of the liver cells can be made out. The result of this extensive necrosis is to make the connective tissue framework of the liver more prominent. Amongst this connective tissue numerous small bile ducts may be seen. In the places where the degenerative process is not so advanced, comparatively normal liver cells are observable which show a small amount of fatty change. A small-celled infiltration is evident in the connective tissue framework of the portal system.

Sections of the kidney show varying degrees of degeneration of the cells of the convoluted tubules. Comparatively normal tubules may be observed deeply bile stained; other tubules show, in addition to this bile staining, necrosis of all the cells lining them. At other points in the kidney cortex, necrotic changes may be observed without the pigmentation of the cells. A few of the tubules show fatty degeneration. Most of the convoluted tubules show some abnormal condition, but the glomeruli and the collecting systems appear normal.

I am indebted to Dr. Hertz for his permission and to Dr. Ryffel and Dr. Laidlaw for their help in reporting this interesting case.

R. CURLE.

Letters from Guy's Men on Active Service.

A Small Advance Dressing Station.

My dear old Man,

Many thanks for your letter; I was glad to get it. Well, I will endeavour to tell you something of our doings. Our division has been relieved from Ypres, and are now having a more or less easy time in a quieter part of the firing line. This they well deserve, as no doubt you have seen from the papers that holding Ypres is no sinecure. Our little lot were under continuous shell fire for about three weeks; by this I don't mean that we were the objects of German fire, but it was impossible to get out of it. We kept shifting our position from farmhouse to farmhouse only to be shelled out every time. Once I thought we really were in the cart. Gillett and I were with 3 stretcher squads at a little estaminet which was being used as a collecting station for the Scots' Guards, when, lo and behold, up comes Mr. Jack Johnson in the back garden; Mr. Johnson No. 2 took the tiles off the house; No. 3 pitched just in front, and the fourth one found the road.

I am trying to get a transfer into either the Gordons or the Borderers, but I'm afraid it would mean coming home, and that would take too long, and I'm sure if I saw the lights of dear old London I should never come out into this again.

It has been bitterly cold for about a week; a hard frost all the time, and everywhere covered in snow. Fortunately it is warmer again now, but during that week we had a tremendous number of cases of frost bite.

As I said before, we are having quite a festive time for a bit now compared with past experiences. Of course, the trouble out here is that one gets so beastly relaxed and everything seems to upset one's intestines. The cooks manufacture a kind of stew; I suppose, really, it isn't bad stuff, but the very smell of it upsets me: it's the eternal sameness of the grub that does it. A greater trouble than this is keeping clean. Some of the chaps are positively alive and I have caught the wretched things on me, although I manage to get a change of clothing as soon as I can. Isn't it horrible?

Now I've told you all the rotten things, I can get on with some of the funny things.

Last night it was decided by Gillett and myself that my hair was getting too long to be healthy, so, as His Majesty does not supply a hair-cutting saloon on the transport, he decided that he would perform the operation. He was of opinion that a small pair of dressing scissors would meet the case, but I was of the opinion that singeing would be more artistic and less tedious. So he started off in the best approved west-end fashion with a stump of a candle and a comb. Unfortunately my hair has become rather dry and brittle with the vicissitudes of the campaign. and I was at one time in some danger of being burned alive, but eventually by our united efforts the conflagration was checked, and, after cleaning away about a quarter pound of grease from my clothes and person, the venture was voted a success.

Some time ago Gillett and I had the misfortune to be in a house where someone looted a shirt or something. The old girl raised Cain about it, and the result was that everyone in that house had to pay 2s. 6d., as the Major saw fit to dub up 50 francs, the sum she asked for. Gillett and I swore a mighty oath that we would get our half crowns worth of loot from somewhere before we came home.

Now we generally pay religiously for everything we have from the people, and I often think we pay too generously, as they take advantage of it. However, yesterday it was all square as we had two delightfully fat chickens for our half-crowns. You should have seen your old uncle catching the wretched things and letting them go as not being worth the money. Finally we dropped a pail over a pair of beauties. We had them plucked and cooked and eaten under four hours. No, I can sleep at night with a clear conscience!

One of the funniest things was on the day when we tried to milk a cow into a mess tin. Imagine your uncle with a mess tin in one hand and a cow in the other, so to speak, chasing over the bally continent for a ha'porth of milk!

Well, cheer ho for the present; write a nice long letter for Christmas with all the news. Hope to goodness we shall soon be able to have that dinner. Give my love to Whelpton. A. H. S.

December 1st, 1914.

. . . I had the good luck to be with a regiment in the First Indian Division that went over to France. We had a long journey, as we were with a number of other ships which went very slowly, and we stopped at Cairo for two or three days before going on to France.

When we left India we had no idea whether we were going to Egypt or to France, the whole thing was kept secret. After about three weeks in France we were suddenly sent up to the trenches and more or less told to die in them! We had no Reserves at that time and our line was hopelessly weak. Well, we stopped them alright, but had about 200 casualties in eight days, so I was kept fairly busy.

Of course, it is nothing but trench fighting, which is most uninteresting. However, it serves its purpose, I suppose. Now we have plenty of Reserves, and we generally have a week in the trenches and a week out.

As a Regimental Medical Officer one's work is very restricted, and it chiefly consists in dressing wounds and arresting hæmorrhage. The next thing is to get the wounded back as quickly as possible along the line. We get hold of a house near the firing line, if possible just out of reach of rifle fire, and make it into a dressing station. Motor ambulances remove the wounded at night time. If only one had a well-equipped operating theatre here it would be A1, but as it is, one merely acts as a dresser and never sees the cases again. At the Base one would get interesting surgical work.

First aid is applied in the trenches; the wounded are then brought back to me. If there is anything serious I go up to the trenches myself, but, as you can imagine, one cannot do much in a trench. That's how Hopkins must have been killed. It is useless being in the trenches themselves as one can do no good there.

An order has since been issued that we are not to be in the trenches, but at our Aid Post one gets used to Jack Johnsons and bullets after a time; the former play the devil sometimes.

The Regimental Aid Post always seems to be where our own artillery are, so the Jack Johnsons follow us about. Two I.M.S. men were killed by a shell the other day. I was in a house the other day and one of the beastly things fell on it, but, luckily, nothing fell on me. It makes one wonder sometimes whether it will be one's turn next! Two of our officers have been killed, including the Colonel, three have been wounded, and about 260 casualties in the ranks.

It is rotten seeing men you know well, mortally wounded or killed, and it generally fell to one's lot to act as undertaker, which is not a pleasant job. . .

I often long to be at Guy's again, but one gets a good life out in India. I like some of the native soldiers very much; they are very good fellows. I expect you are very busy now that so many doctors have gone to the front. . . .

The Germans are getting a bad time now, thanks to Russia, and if Russia continues to get a move on, the war will be shortened by months.

The Indian troops have behaved jolly well, but they don't like the cold much, and, of course, the conditions have been very abnormal for them. Sitting in the trenches is a poor game when you are feeling cold. There has been very little illness so far amongst the troops. . . .

I have been keeping very fit and have so far escaped the things that fly about in the air, but they come uncomfortably close sometimes!

I have seen some awfully nasty wounds of the hand; the new bullet gets up very badly and makes a very big wound. I think I would rather be a soldier; a Medical Officer's game is a poor one at these times. It is rotten being blazed at and not being able to retaliate. I have got a pistol and a sword, but, of course, I never use them.

I wonder if the Germans will attempt an invasion of England. I don't think they will get very far if they do. We are very well fed, but naturally do not exactly live in the lap of luxury.

Give my kind regards to any friends you may come across. I see a lot of contempories are out at the war. Well, au revoir! Yours,

G. Y. THOMSON,
Indian Expeditionary Force A.
3rd Lahore Division.

From Lieut. Philip Smith, M.O. 4th Royal Fusiliers, 3rd Division British Expeditionary Force.

December 1st, 1914.

. . . I came on here about four weeks ago, and have fairly been in the thick of it since. We were at Yprès, and the attack of the Prussian Guard was made on us on Wednesday the 11th. I will tell you all about it when I return, but I never thought I should return that day! They broke through after a terrific shelling and surrounded the chateau in the cellars of which I had my dressing station! Fortunately they were driven back again by a magnificent charge.

We went a few days ago to relieve a regiment in the trenches near here. I went down to take over the dressing station from the M.O. and found Maitland Scott! We in turn were relieved last night by the Gordons and Old Jamie walked in! I have seen quite a lot of him lately and he fairly enjoys this life—the only one whom I have met who does, though I would ten times rather be here than at the base. The best definition I have heard of modern warfare is, "Months of boredom punctuated by moments of extreme terror."

Bye-the-by, Maitland saw G. D. the other day and said he looked the picture of health. I also met Pryn; he is with a regiment and doing very well.

I am afraid this doesn't contain much news for the GAZETTE. I am very fit, indeed. It is hell for the men in the trenches, but when we get out I have a very good servant to look after me and a nice horse, but I long for some female society. The only women we see are the poor refugees. Remember me to Sam, H. N., Ham Gould, etc. Ever Yours,

PHILIP.

"Les jours se suivent."

Dieppe,
November 28th, 1914.

If there is one force in all the gamut of human emotions which in the end will prove stronger than all the rest it is that of inertia—the force of habit. Time was when the sight of a blessé, pale, muddy, and in more or less fragmentary clothing raised an expectant thrill in our breasts; now we simply remark with a shrug (for we are all assimilating the Gallic temperament), "only ten to-night," or half a dozen, as the case may be, in much the same tone as I imagine Stevenson would refer to a break of a thousand or so.

But if we are acquiring the Gallic temperament there is at least one institution whose infinite cussedness age cannot wither nor custom stale. And that is Monsieur Lebureau. In England where we always try to be impersonal we refer to red tape, in France the whole system of bureaucracy, root and branch, is summed up in that one delicious word. I always picture him, my ideal Monsieur Lebureau, as a provençal, pompous, voluble, fussy, cringing, abusive, a born actor with the keenest eye for "points," but a business man, no!

You have to see him on some apparently trivial business, taking one or two packages from the customs, getting a military ticket on the railway, some formality connected with cards of identity. With a crafty smile he peers at you from his little wire cage, while you are wondering how a man can go without shaving for so long and yet not grow what could be conclusively called a beard. You start quietly enough: the pigeon-hole in the third corridor on the right is where you should have gone; you may, if you are foolish, point out that for the last month you have always applied successfully to this one, but that does not alter your fate. Full of hope you try the second, but there it seems that no one has ever heard of the business in hand, and so on to the third, fourth, and fifth, when, perhaps, you get a little abusive, and fun begins. With a wealth of gesture that we Northerners have long since discarded, he tells you how his life has been made a hell by these fool English; that he and everyone else work night and day making paths easy for a stiff-necked generation that will brook no guidance; then, as the storm subsides, you find that the first pigeon-hole of all was where you should have gone—and so it starts again.

The vagaries of Monsieur Lebureau are indeed marvellous. The other day our ambulance in Paris was stopped in one of the main streets and the Union Jack which we carried solemnly removed. We had no right to carry it, it seemed, in spite of the fact that the whole hospital, staff, and equipment is English. A friend of mine, a Russian, who has spent twenty years of his life in practice in Paris, and was made a Chevalier of the Legion d'Honneur a few years back for organising a Medical Congress, applied to the Red Cross for a post as surgeon in one of their hospitals. He was politely refused by the official to whom he was presented. "You see," he said, amiably, "if we gave

a Russian doctor anything we should have Germans applying next ! "

Here in Dieppe the great stumbling block is amputation. A man without a limb is, as the French surgeon put it, a burden to the State, in other words, there is the question of a pension; and so you have the inspiring sight of English surgeons compelled to preserve limbs, fingers, etc., which are bound to be useless and in some cases constitute a real danger to the patient, simply because of the Government's reluctance (I am happy to say it is not our own) to pay out adequate compensation.

During the last few weeks I have had occasion to visit a number of voluntary English hospitals in various parts of the country, and any doubts I may have had as to English competence have been finally expelled. Situated in most unlikely spots, old country hotels, museums, chateaux, large secondary schools (and anyone who knows the *lycée de province* will realise what that means), and everywhere I have found them marvels of comfort and organisation. The nursing staff—how many French soldiers, I wonder, will live to bless his *bonne nurse anglaise*—bright and efficient (at home people do not realise what unskilled nursing can be like), make a little oasis of cleanliness and smiles amid the squalor of the surroundings. I could go on for long enough on the virtues of English nursing, the medical staff so quiet and so sure of their results. I don't wonder that they say the French hospitals have a sudden desire for improvement the moment an English hospital is started in the town.

Only yesterday I came across an old Guy's nurse in the College here, a dreary wilderness of a place full of rats, lice, and other abominations, struggling to make the sufferings of a ward full of wounded Germans a little lighter. " What can you do ? " she said, pointing to the rotting boards thick with dust. " They don't know the meaning of the word clean."

I see that the —— the other day was reviving the old fetish of dum-dum bullets. It is a libel as old as the hills which, together with the white flag stories, every war sees bandied about on both sides. Personally, and every surgeon I have spoken to agrees with me, there has been no wound in any English hospital where it could be conclusively said that a dum-dum bullet had been used. The so-called explosive effect I have seen best exemplified in two cases where, owing to accident, the patient was wounded by one of his comrades at short range. In one, an English soldier who was wounded in the trenches by a comrade cleaning his gun, the bullet took off the whole of the internal condyle of the femur and the inner tuberosity of the tibia with an effect like a sword stroke. The other, a Frenchman wounded by a comrade, standing behind, in firing a volley, the bullet passed through the two bones of the fore-arm, making a wound of entrance of 3 inches by 1½ inches, and of exit 3 inches by 6 inches. Both of these cases would have been quoted by the unwary as instances of dum-dum bullets used by the enemy.

At the Salpetrière hospital in Paris the other day I had pointed out to me the almost alarming increase in insanity brought about among women as a direct result of the anxiety and suspense of the war. It is early yet to generalise, but it is possible that we shall find, not the loss of our young men, but the sanity of our mothers the longest price we must pay for war.

G. H. F. G.

Letter from an Orderly in the R.A.M.C. to his former Colleagues in the Works Department.

Boulogne.

Dear Mr. Davis and Shopmates,

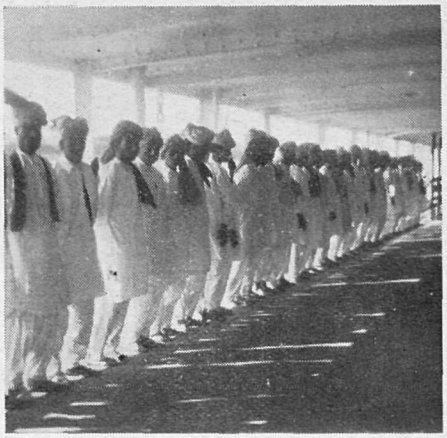
You must excuse this scribble, etc., as we are going full steam ahead for Paris. We brought a trainload of wounded British and German from Yprès to Boulogne to be put on a hospital ship, but they find on arrival that the sea is far too rough, so we have been ordered to proceed to Paris with wounded. We are now travelling while I write. I have to write this in advance as I should have no time on arriving.

Well, we are having horrible weather just now, and I am thankful not to be in the trenches. Your letter sort of cheered me up this morning. I received it whilst we were standing for orders at Boulogne—the " nom de plumes " amused some of my fellows. It was like Christmas last night: we had a tonic of rum to keep the cold out, and the doctor ordered champagne and stout for patients. I was busy popping the champagne and stout and issuing packets of cigarettes which had been sent out from home to the wounded: the cigars were missing. We have several of the wounded Kaiser's Guards on the train; I have six massive great brutes and a captain of the élite Prussian Guards. The captain can speak English quite fluently. Me and another chap was speaking to him yesterday, and we asked him what he thought of it and how long it would last. He is quite nice to speak to, but he is confident that the English cannot last longer than April and that Germany will win. We told him he was being led astray; he says he would not like to be in the English army. I told him the Kaiser has the cream of his army for a month trying to break through Yprès to Calais, and they have not done it yet. After the terrible cutting up they had the other day (which no doubt you have read) should open their eyes and change their opinion; but he only laughed. He has a fractured thigh due to shrapnel. They all stand well over six feet.

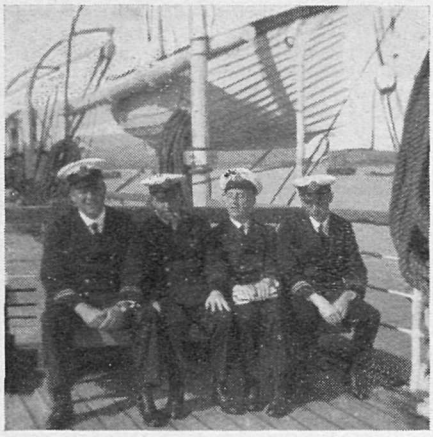
They don't mind being taken by the British. . . . They ask if they are going to England, and when we say " yes " their eyes glisten, they laugh and are quite happy, but if we say *Paris*, they dread it. We keep our own prisoners and the French keep theirs.

Well, we are having a long journey this time; we left Yprès at 7 last night and hope to get into Paris

The after 4 in. Gun being fired.

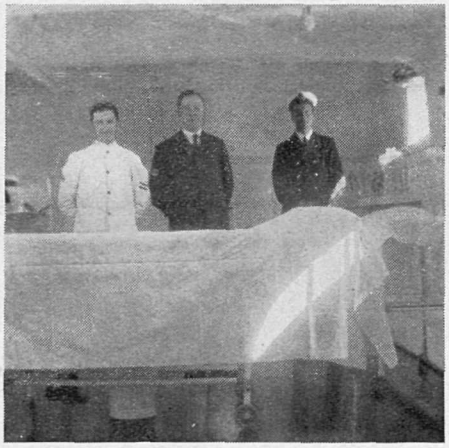


Lascars on H.M.S. *Soudan*.

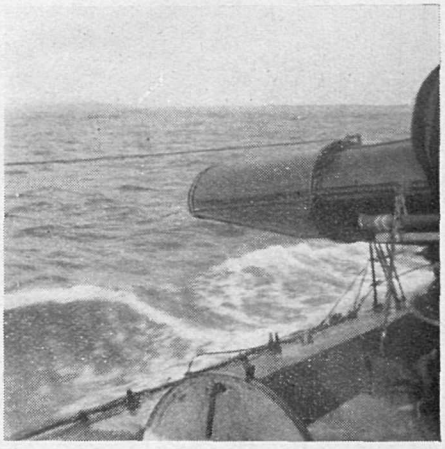


Group taken on H.M.S. *Soudan*. Vicary (Guy's), Kynaston (Guy's), Jones and Endean (Guy's). It will be recalled that Kynaston, who was formerly attached to H.M.S. *Devonshire*, died from pneumonia at Dunstaith on November 14th.

"Nigger." Weighs 13 lbs.!



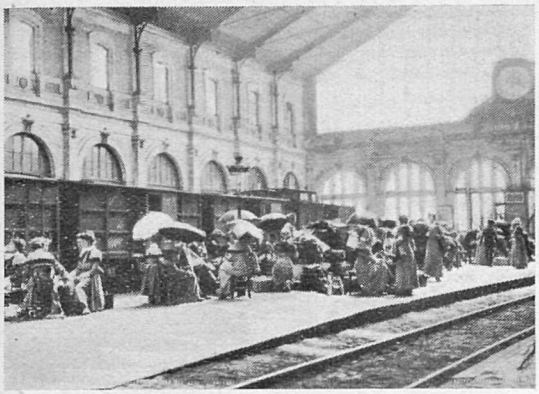
The Operating Theatre on H.M,S. *Soudan*.



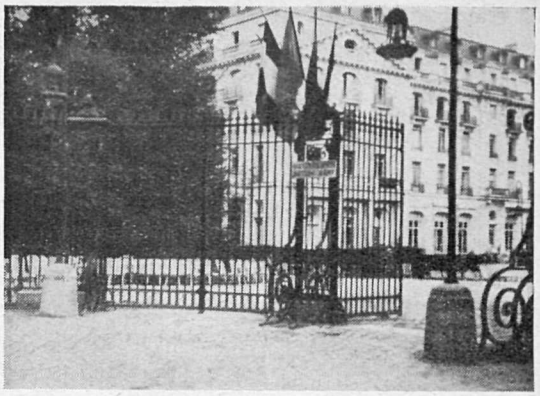
Torpedo Tube on a Torpedo Boat Destroyer.

H. PARRY PRICE,
H.M.S. *Sheldrake*.

and Nurses in Pictures.



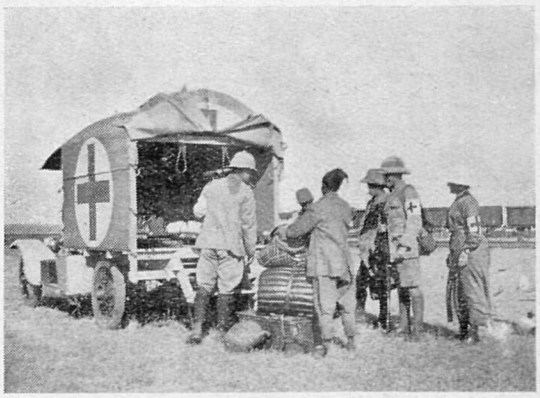
Lunch at Nantes *en route*. Awaiting orders.



No. 4 General Hospital. The Gates, early morning, Versailles.

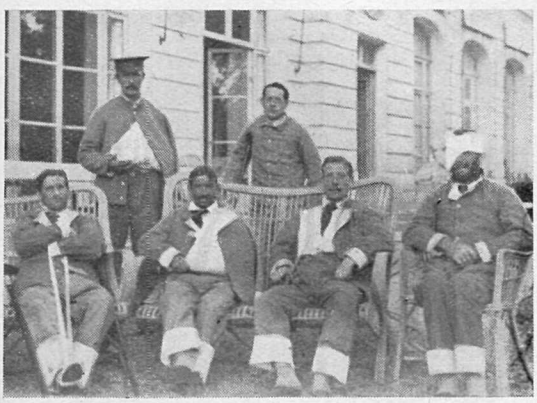
Guy's Platoon, Officers' Training Corps (University of of London), at Perivale Camp.

A. Gordon, Guy's Hospital



The Motor Ambulance, with the Hospital Train in the distance.

From Miss Margaret Atkey, now Matron at Nairobi. (See letter in this issue)



My Six Scotch.

Convalescent Tommies, inside the gates, sunning themselves, Versailles.

The two upper and two lower pictures were sent by Sister Jentie Paterson, when at No. 4 Base Hospital, Versailles. Miss Paterson is now at No. 5 Clearing Hospital, near the firing line, in Belgium.

late or early in the morning; it is now 6.45 p.m. and we have not passed Amiens.

I was very pleased to hear from you all again and to know that you are well and going strong; I shall not know the shop when I return. Well, how does Harry stand for the subscription, I mean conscription? Tell him he'll have to be a bomb ducker; Charlie will be alright, he is a bomb ducker, and you want to be a Jack Johnson ducker, too. They make a hole big enough to put a furniture van in; they kill three birds with one stone—dig the grave, kill you, and bury you afterwards.

I shall certainly have to look out for the "splint maker." I wonder where he is. We get some funny splints here at times; we don't put them on, but we have to redress the wounds on the men.

Morphine tartarate is used freely, and the poor fellows want it, too, in order to get a little sleep, for some are wounded most terribly. It's butchery, not warfare!

In South Africa it was difficult to find some of the small bullet wounds, but here it is a job to find the man at all. Wicked! And they don't suffer with one wound. I have a man in my coach now: both knees shattered, shot in the chest, back and arms! That's with shrapnel! A London Scottish man next him: bullet wound in chest and came out of back, leg and arm; he is paralysed below the umbilicus. I have to pass the catheter every six hours. There are three on the train like this.

Wednesday.

Well, we have been to Paris. The London Scottish died, and we put him out at St. Omer, and handed him over to the French Hospital. He died of internal hæmorrhage. Poor chap! A nice fellow, 20 years old.

We arrived in Paris at 11.30 on Sunday night and finished unloading at 1 a.m. on Monday. We had high jinks in Paris on Monday. . . .

You must excuse this scribble, as we are still travelling on this proper rag-time railway. We got back to Boulogne from Paris and were then sent to a place called Merville, just below Hazebrouck. We are now travelling back to Boulogne with about 250 wounded and sick. Some one has just given us a rum issue, as there is a thick frost this morning, with hard rain and sleet.

Remember me kindly to all. I hope you are all quite well. I am fine myself except for a bit of a cold and sore throat. Best wishes to all the lads Roll on civilisation and home,sweet home. England for ever! (Well, we shall arrive in Boulogne early in the morning. It is now 8.30 and I see no hope of sleep to-night, but still, roll on Angleterre!

Well, good-bye, chaps, will write you again later. Yours, One of the B'hoys, W. MORRIS.

P.S.—I reckon this driver is drunk. We shall go into the Seine in a minute. Don't laugh; just had half a bottle of champagne. Beastly stuff!

Appointments.

The Distinguished Service Order.

The following has been appointed a Companion of the Distinguished Service Order;—Capt. Malcolm Leckie, R.A.M.C., for gallant conduct and exceptional devotion to duty in attending wounded at Frameries, where he was himself wounded.

Royal Army Medical Corps.

6th London Field Ambulance: Capt. J. W. Bird, to be Major (temp.).

To be Temporary Lieutenants; A. Read Wilson, C. F. Constant, W. Elwood, R. O. H. Jones

A. N. Leeming, R.A.M.C., 6th Oxford and Bucks Light Infantry.

Dudley G. Greenfield, M.D., F.R.C.S., is attached to No. 10, General Hospital, and is now stationed at Rouen.

Lieut. F. Cook, R.A.M.C., No. 4, Clearing Hospital, British Expeditionary Force.

Indian Medical Service.

Capt. F. A. Barker, I.M.S., 110th Indian Field Ambulance.

Attached to other than Medical Units.

C. H. Brewer, to be 2nd Lieutenant, 2nd Battalion, Bedfordshire Regiment, Expeditionary Force.

Lieut. P. R. Bolus, to be Captain.

Surgeon-Capt. Abraham Thomas, from 2nd Welsh Brigade, Royal Field Artillery, to be Major.

E. H. Musgrove, to be Captain. Brecknock Battalion, South Wales Borderers.

C. E. Thomas, to be 2nd Lieutenant, 5th Buffs, East Kent Regiment (India).

M. G, Whitten, 6th (R) Brigade of Artillery.

Civil.

Dr. Newton Pitt, has been elected a Censor of the Royal College of Physicians.

Dr. M. S. Pembrey, has been appointed an internal examiner in physiology for Medical Degrees, University of London.

University of Cambridge.—The State Medicine Syndicate has appointed Dr. Maurice Craig, Gonville and Caius, to be a member of the managing committee for the University Diploma in Psychological Medicine; to hold office for three years.

Dr. G. S. Graham-Smith, has been appointed a member of the M.D. Degree Committee until February 28th, next.

University of London.—Recognition of Teachers.

Dr. Patrick P. Laidlaw (Pharmacology), during the absence of Dr. Clark on military service.

Dr. G. N. Bartlett, has been appointed Medical Superintendent, Exeter City Asylum.

W. S. Lakeman, has been appointed Dental Surgeon to the Chalfont Epileptic Colony; and Hon. Dental Surgeon to Hillingdon and Uxbridge, Cottage Hospital.

Manipulative methods of treatment in the surgery of bones and joints.

CLINICAL LECTURE BY W. H. TRETHOWAN, F.R.C.S.

Gentlemen,—Since I have been in charge of the Orthopædic and Massage departments of the Hospital I have interested myself in those methods, with their scope and application, of that branch of surgical treatment of affections of the limbs and trunk which is variously known to you as manipulative or "bloodless" surgery, forcible movements, or wrenching, and to the laity as "bone-setting," and I thought that my reflections on this branch of surgery would be of sufficient importance and interest to you to form the subject of a lecture. I should like to describe to you the general principles of all those minor operative measures of a non-open kind which are included in the above terms, to point out their special utility in surgical practice, and to discuss their relationship to open operations. Closely allied to the question with which we are to-day dealing is that of the principles of splinting and supporting apparatus, or appliances, but this is too large a subject to enter upon here, and must be considered in a subsequent lecture. As regards massage, also associated with manipulative procedures, I propose to bring to your notice only its merest essentials.

As students you are well aware of the every-day illustrations of the use of forcible movements in the reduction of deformity due to acute fractures and dislocations, but, beyond this, I am sure you would admit a painful vagueness of mind concerning such matters as: when to rest or move an affected joint, when to expect anchylosis or mobility; if anchylosis, then what should be the position of the joint, and how can this be obtained; if restoration of mobility is possible, then can this be done quickly by the surgeon, or must it be left wholly to the slower and more persuasive methods of the massage and actino-therapeutic departments. You will have difficulty in deciding whether an old and imperfectly united fracture demands remedying, and if so, whether by osteoclasis or by cutting down and plating; or again, when an old dislocation shall be reduced by the ordinary methods of the acute stage, or by operation. In your fractures near or involving joints you will wonder how long to immobilise for the benefit of the bone, and when to devote your greater regard to the restoration of the movement of the joint, and in your treatment of stiffness and contractures of muscles and tendons, and their resulting deformitles, you will experience by no means the most easy and rapid of surgical results.

The proper recognition of the mechanical principles underlying treatment in bone and joint surgery, which I am going to emphasize in this lecture, is as necessary, both for the ultimate welfare of the patient and for your reputation for ability as a surgeon, as a knowledge of the pathology of the conditions you are treating. It must be admitted that the treatment of the later and more chronic stages of these affections is often not carried out with that vigour and interest shown in the earlier and more acute stages. Often this is due to the slower rate of progress made by the patient later in the disease, as compared with the initial and rapid improvement that may have followed some open operation, and the greater tediousness, and closer personal attention necessary on the part of the surgeon for the so-called after treatment; or the cause may be the lack of appreciation of the importance to the patient of the minor disabilities resulting from the original severe condition.

The time and expense incurred by illness is more irritating to the patient in the later and slower stages, and it behoves us to be particularly careful to see that we carry out all possible surgical measures without undue delay. Treatment must be by the most rapid measures, as well as being efficacious. Another cause of protracted treatment is the avoidance of forcible manipulations from fear of causing a recrudescence of the disease in the part, or of damaging contiguous structures, or from failure to recognize that some deliberate increase of disability to the patient by some manœuvre of the surgeon may result in a curtailment of the whole period of illness. It is often necessary that we take our courage in both hands, and not always adopt a policy of masterly inactivity because we are not absolutely sure of the pathological process with which we are dealing. It will, for instance, in treating disease of a joint, often be difficult to decide whether we are dealing with the active morbid process itself, or with its after-results; the one may demand rest, while the latter necessitates all the measures which actively assist return of function. Again, we must be careful, in the treatment of set deformity, not to relegate to appliance-makers essential details of treatment which should be carried out by ourselves. The function of an apparatus is to ensure rest, or relieve weight bearing, or to combat temporary or permanent weakness;

to ask an instrument-maker to correct deformity is an admission of inability to perform some surgical operation. A bent limb cannot be put into a straight apparatus, and some of the more intelligent instrument-makers, recognising this, and possessing a better knowledge of mechanics than the surgeon, find themselves forced, in order to avoid doing inefficient work, to carry out the requisite manipulations and corrections of joints, to the discredit of surgeons, before supplying their splints.

Forcible manipulations do not demand such a high degree of technical skill as open operative surgery, so there can be no excuse for their utilisation to the full. In varying cases they will be used as preliminaries or adjuncts to, or perhaps instead of, the more radical operative measures. In the minor ailments particularly, such as sprains of joints and muscles, with the resulting stiffness from adhesions, the beneficial results of vigorous manipulations are not appreciated as they should be, and the fear of lengthy disability while under treatment by medical men often compels the sufferer to resort to the assistance of unqualified practitioners. There is no need whatever for this. The recognition of the principles of skeletal alignment; the function, range of movement, and mechanics of joints; the muscular balance; the influence of gravity and weight bearing; the relation of pain and fatigue to the altered mechanics in abnormal conditions; the restoration of function of muscles and bones in diseased or injured condition; the pathology and anatomy of the affection; and a knowledge of the most rapid methods of alleviation of disability, will enable you to acquit yourself of the charge that the bone-setter possesses some special knowledge of which you are deficient. The actual details of manipulative processes are easily acquired if you recognise the principles.

All Manipulative procedures may be divided into the two classes :—

1. Gradual movements. In these are included —passive movements, and active; the latter are either free or against external resistance, and local in application, or as general gymnastics. Gradual movements are usually preceded by massage.

2. Forcible movements, firmly and vigorously carried out, usually through a greater range of action, and always under an anæsthetic. These may sometimes with benefit be preceded by a short course of massage; after the movement, if we have quite corrected the deformity, we apply no retentive splint or apparatus, but follow up the manipulation at once by vigorous active and passive exercises. If, on the other hand, the correction cannot be completed in one operation, we apply apparatus under as much pressure as is safe in order to retain the correction already won, and to stretch and adapt the soft parts, preliminary to a further forcible correction in a few days. Thus we correct by as many stages as is necessary. Later when the anatomy is corrected, we resort to massage and exercises to restore the function to the part.

In this connection, without going into details, I will call your attention to the importance of acquiring a good technique in the application of plaster of Paris work in surgical conditions. As a temporary retentive apparatus nothing can equal the efficacy of plaster. No emergency apparatus but this can ensure your being able to retain a limb precisely in the position you wish. Plaster work has been very little used in this country, compared with its wide application in the Continental and American Schools, and it is partly because of this that the manipulative treatment of acute fractures has been so much neglected. Temporary splints of the most efficient kind, and of all sizes, can be used with the greatest satisfaction in most types of fracture. These are all made with plaster bandage; the old Croft and Bavarian splints are an abomination, and should be discontinued. You can learn the few details of plaster technique in a very short time on any Monday afternoon in the Out-Patient department. There are no dangers in plaster splints if a little care is devoted to a few points in their application. A few misapprehensions may be removed; no healthy joint becomes stiff and anchylosed by fixation in plaster, and the objection on account of muscular atrophy is too much exaggerated in proportion to the advantages gained in other ways by the use of the plaster; besides, it is quite easy to make the splint removable if it be wished to carry on massage and movements at the same time as the fixation.

Let me first insist that you always retain a clear perception of the second important factor in the treatment of any surgical condition. There is no fear that your recognition of the first will not be clear enough, viz., the restoration of the anatomical continuity of the diseased or injured tissues, but you must never cease to bear in mind, as a separate consideration, of equal importance with the first, the restoration of function, or usefulness, of the affected limb or part. You will then always remember to devote the whole of your surgical resources as much to the completion of the cure by assisting the return of use, as to the preliminary repair of

damaged structure. The treatment of a fracture, although the bone is united, is incomplete until the muscles are re-developed, the circulation normal, the joints and tendons freed from stiffness, and the patient able to use the limb normally. A sprained or dislocated joint should demand your attention until the joint can be carried actively through its complete range of movement without pain. A club foot is not safe from relapse until the patient can actively hold the foot in the over-corrected position. The limb and patient must be considered as a whole, for if a joint is to remain permanently stiff, that is, without a return of its particular function, then you must see to it that the defective joint is anchylosed in such a position as affords the maximum degree of usefulness to the limb or body as a whole; otherwise, secondary disabilities are bound to follow. When the powers of recovery of function by the body itself have done their utmost, and usefulness is still deficient, you must consider what temporary or adventitious aids, in the matter of appliances, can be utilised. By your surgical measures you must reduce your artificial aids to the minimum, be aware of the indispensible support you need, and see that your appliance fulfils the conditions demanded of it.

Now let us consider the question of the muscular balance about a joint. Every joint has a certain normal range of action in two or more directions, necessary for the perfect function of the limb. It is surrounded on all sides by muscles, or their tendons, arranged in antagonistic groups which are often unequal in strength. Somewhere between the extremes of movement, usually about the middle of the range of action, and best seen when the body is lying at rest, are the "middle positions" of ease, determined for the time being by the absence of voluntary action in any group. These "middle positions" are those assumed when the joint is the seat of synovial inflammation, and in which the capsule is allowed to become slack, and the capacity of the joint at its greatest. The unequal strength of antagonistic muscle groups is an adaptation to the other forces acting upon the joint, viz., gravity and weight bearing, and the assumption of the erect position. The joint capsule and ligaments, and the associated muscles, are maintained at their proper working lengths by daily function and exercise. Where normal range is not carried out to the full at frequent intervals, tendons, muscles, ligaments, in fact all the soft tissues on the side of the joint away from which the movement is deficient, undergo an adaptive shortening of structure; soon the patient is not able voluntarily to overcome this "contracture" by means of his antagonistic group. The contracted group becomes deficient in muscular power because it is "contractured," and the antagonists, because they are now never able to contract to their full, are also paretic from permanent overstretching. Thus the muscular balance around the joint is upset, and we get increasing limitation of range of movement. Limited movement tends to further limitation and loss of power, and, if the result of old joint inflammation, tends of itself to give rise to pain. All this without regard to the condition originally causing the upset of muscular balance; this may be due to paralysis of one group, to posture assumed for a certain interval, or to local intra- or extra-articular disease or injury. With the protracted assumption of a deformed position of the joint, the bones become altered both in internal architecture and external configuration, in accordance with Wolff's law, which tells of this adaptation of bone to meet the new conditions of position and function. In treating such a condition of upset of muscular balance, it is obvious that we must first do for the patient what he cannot do for himself, that is, stretch all the soft structures to their full, and keep them so until their tendency to return to the contracted condition is abolished, and they remain at their original length; the patient will not be cured until he can voluntarily carry the limb through the full range of movement of the normal joint. In dealing with such a contracture of a joint our method will be determined by the age of the deformity, its severity, and whether the joint is or is not the seat of old inflammation. As all the soft tissues are involved in the contracture, it is obvious that tenotomy alone will not suffice; indeed, the forcible rectification can often be as well done without tenotomy, *e g.*, in straightening a flexed knee, or correcting a baby's club foot.

Some joints can be quite corrected at the first sitting, there being no danger of overstretching the vessels and nerves; for example, the hip and ankle joints. On the other hand, you must not on the first occasion straighten the knee further than the pull on the popliteal vessels will allow; in this case, fix the knee in plaster as straight as permissible, then leave it so for a week, when it will be found that the popliteal structures have considerably lengthened in the interval, and you can complete your correction. Correction must be carried to the fullest extent away from the direction of the deformity, and you must remember to over-correct whenever possible, and

retain over-correction for the requisite period. The retention of over-correction for some time is necessary to lengthen permanently the shortened tissues, and prevent relapse. Only after the return of voluntary power, assisted by massage and exercises, can the correcting splint be omitted. In correcting a joint, it should be seen that this is done in two or more planes if necessary, in order to get the maximum position of utility, *e.g.* care should be taken to correct the backward and outward subluxation, and rotation, in straightening a flexed knee. If there has been articular disease, and it has been decided that the joint is to remain anchylosed, then the joint must be fixed in that position in which it is most serviceable; the hip joint must be hyper-extended and slightly abducted, with the foot looking almost directly forward; the knee joint hyper-extended; the ankle at right angles; the shoulder abducted somewhat; the elbow flexed to just beyond a right angle; and the wrist hyperextended. If we are dealing with the results of joint injury or inflammation of such a nature that we can reasonably expect a restoration of movement in the joint, then probably no retentive splint will be required at all; in fact, it will be decidedly more hopeful for the ultimate outlook of restoration of movement if we use no splint or bandage whatever, but go right on to passive, and especially active, movements and massage. In correcting any deformity, it is good surgery to stretch all the soft parts by forcible manipulation and retentive plaster to the very utmost before we contemplate altering the shape of bones by open operation. Only thus can we say how much bone is to be removed; indeed, we may find that an open operation on the bones now becomes unnecessary. Otherwise it may happen that we remove too much of the skeletal structure, with serious permanent disability. In the condition known as Volkmann's Ischæmic contracture, with severe contraction of all tissues on the palmar aspect of the fore-arm and fingers, it has been the custom to remove an inch or so of both radius and ulna in order to adapt the skeleton to the diminished length of flexor tendons. But this method of treatment does not recognise the upset of muscular balance. All the tissues on the flexor aspect must be lengthened by repeated forcible correction, with retention by splint, and the stretched extensors allowed to recover from their over-stretching, the restoration of muscular balance being assisted by massage and exercises when the deformity is abolished. Again, the adduction deformity in traumatic or adolescent coxa vara and the inability to abduct the hip joint, are due to fixed contracture of the adductor muscles, and not to the impact of opposed bony surfaces; it should be corrected by tenotomy of these muscles, and by stretching of both the adductors and external rotators.

Turning to a consideration of the mechanics of the skeleton, we must recognise that the bones also have their functions, and are adapted for certain purposes; there is a skeletal, as well as a muscular, balance. The bones are levers for the transmission of force, and in the legs and trunk they serve also to transmit weight. The joints are adapted to the functional strains transmitted through the bones. We must bear in mind the importance of skeletal alignment, both as regards the individual bone and the whole limb. If the skeletal alignment is altered, as the result of fracture, or of bad static conditions, we see the evil result at once on the joints and muscles. It has been said that one-third of all pain to which the human body is subject is due to gross mechanical causes, and can be relieved by mechanical procedures; a great proportion of this mechanical deficiency is to be found in the skeletal and muscular systems. When an abnormal stress is felt by a joint as the result of skeletal mal-alignment, the patient experiences muscular fatigue, and joint pain; there is a reaction in the joint, the irritation due to unequal bearing on its surfaces, the so-called traumatic arthritis, such as is seen in the ankle-joint after an incompletely reduced fracture at the lower end of the tibia and fibula, or in the villous arthritis of the knees which may follow an old knock knee. The joint squeals and wears badly, just like the hinge of a badly hung door, or as the bearings may get hot in an engine. A patient, the muscles of whose feet and legs have not the strength and tone necessary to meet the demands made upon them, and who, therefore, habitually assumes the abducted position of the feet, the position of rest, in which the strain falls upon the ligaments, instead of the adducted position of muscular activity, alters the normal strain upon the foot and ankle-joints, and thus suffers much pain. The astragalus rolls inwards, and knock knees develop, causing further strain upon the knee-joints. Pain is increased from muscular spasm provoked by nature's efforts to maintain efficiency, in spite of the bad mechanics. The abnormal strain on the bones is felt by the epiphyses, with irritation and congestion at the epiphyseal line, and consequent overgrowth and increase of deformity. Many of the so-called growing or rheumatic pains experienced by children are attributable to this

cause. Nothing favours and produces deformity like deformity. A short leg gives spinal curvature; a flexed knee produces a flexed hip, and a flexed and adducted hip causes pelvic obliquity and increases the shortening of the leg.

As restoration of function necessitates correct anatomical reposition, the importance of the reproduction of the alignment and normal length of a deformed bone is apparent. It will many times be unnecessary to cut down upon a mal-united fracture; simply breaking down the recent fracture by hand, under an anæsthetic, correcting the alignment, and fixing in plaster as from the beginning, will be sufficient. The type of fracture in which this may be done successfully is the transverse, or very short oblique injury, with angular deformity. This manual osteoclasis can be done up to within a few months from the original injury, even in adults. Beyond this stage an open operation will be necessary. In reducing a fracture you must remember the normal curves and shape of the bone; a tibia put up in a straight line, without its normal curve being observed, as was the case in a boy sent to see me, will result in a painful valgus deformity of the foot. The treatment here was to break down and reduce the deformity. Another angular deformity in the shaft of the femur in a small boy, producing half-an-inch shortening and scoliosis, led to a claim for damages, the claim being made large on account of the considerable limp and deformity. Cases of Colles' fracture with deformity coming for treatment several weeks after the accident, can be easily corrected by manipulation, or, if particularly difficult, by the Thomas wrench. If, after the first few weeks of treatment, you are not satisfied with the position of a fracture, as shown by skiagraphic examination, give it an anæsthetic and boldly break it down again with your hands, and re-set it; it will save much trouble and vexation in the long run, both to yourself and the patient.

Reverting to the subject of joints, I would impress upon you the importance, when considering an affection of any joint, of recognising the total range of movement in the normal, and of ascertaining what is the deviation from this in the joint under examination. Many conditions, both intra- and extra-articular, lead to limitation of movement, in degree varying from total anchylosis to the very slightest diminution of range in one direction only; in fact, some painful joints, whose range seems absolutely perfect, are at once rendered painless by being passively put through their whole range under anæsthetic; this, for example, may be seen in the foot and ankle joints in many cases of weak painful feet. The pathology of the joint condition causing the anchylosis will sometimes assist us in determining whether we shall make attempts to restore movement by forcible manipulations. If there is reason, from the history and examination, to suspect that the active disease has now ceased, and that the structures of the joint are not seriously impaired, such a condition exists as would justify attempts being made to procure the return of mobility by forced movements. Sprains and other minor injuries of the tissues within and about the joints are very liable, under ordinary treatment, to be followed by tedious and disabling limitations of movement; these are due to adhesions following the tears in the various tissues, which unduly limit the stretching or movement of the muscles, tendons, ligaments and synovial membrane. The adhesions are very sensitive, and cause much pain when pulled upon in the movements of the joint, so that the patient refrains from these movements, and acquires a fixed and limitated range of action. Some of the most disabling adhesions are extra-articular, such as we find especially in the shoulder. Mere adhesions will cause any degree of limited movement; the other symptoms are pain on movement, often elicited only when the joint is moved in certain directions. Pain, besides being due to the sensitive adhesions, results from irregular pull on matted structures. Extra articular adhesions can also occur from gouty or chronic inflammation in the fibrous structures about the joints. In cases suitable for breaking down, the joint is not usually hot, but is rather inclined to be cold, and of pale or dusky tint; if heat follows exercise it quickly disappears on rest. If a joint is almost completely fixed, but what movement left is smooth, the joint is practically healthy, and the result on manipulation is good; in such a case the stiffness is probably due to extra-articular causes. Many cases are cured by manipulation although an exact diagnosis cannot be made; many give no history of injury. In some cases of pain only, or pain and stiffness, which are relieved by manipulation, it is difficult to say how the movement has acted. Joints with chronic effusion, but without heat, can be manipulated.

In manipulating joints an anæsthetic must always be given, to produce relaxation of the muscles, and to avoid tearing them. The limb is grasped in such position as avoids the possibility of fracture, and carried fairly rapidly and smoothly throughout the complete range of

movement, with special attention to those directions in which the movement was most limited. The rotation movements are begun first, then the flexion, but the whole range must be gone through, in the various combinations of movements, thoroughly, but without causing damage to the muscles and ligaments; always keep up direct extension on the limb, *i.e.* trying to separate the joint surfaces as much as possible, when moving. The adhesions may be felt to give way, or not. Manipulations must be followed up immediately by massage, and active and passive movements; pain, felt at first, quickly disappears in a day or so. Should some adhesions re-form later, repeat the manipulation.

Other conditions in which manipulations are good are; As the initial treatment of a sprained joint, to restore the lacerated capsule, before the wool compression or strapping is used; the reduction of displaced muscles and tendons, *e.g.* of the peroneus longus, or long head of the biceps, or in acute wry neck from this cause; reduction of a displaced semilunar cartilage in the knee; for painful or rigid flat feet; for suggestion purposes in cases of neuromimetic joints.

The frequent cases of stiff shoulder which are cured by manipulation are frequently diagnosed as osteo-arthritis. It follows direct injury to the shoulder, or through the arm, but sometimes there is no history of injury whatever. Movement may be almost or quite absent; pain is present, but may not be severe, unless attempts at movement are made, except at night, when the pain is always much worse, and the patient is unable to lie on the bad arm.

In the knee, many cases of suspected injury to the internal semilunar cartilage are only adhesions following a sprain; the internal lateral ligament and the tissues on the inner side of the joint are very liable to injury. All cases of injury to the knee-joint where certain movements remain painful or limited should be manipulated with a view to restoring the full movement Where the semilunar is affected, Marsh says that when the displacement of the cartilage is slight, the movement of the knee is slightly or not at all interfered with, and the only complaint is that the joint is always uncomfortable, and becomes painful, or a little stiff and over-warm after exercise. Manipulation will not permanently restore a recurrently dislocating semilunar, but it can reduce a dislocation which has existed for months.

In the firmer fibrous partial anchylosis which may have followed acute synovitis, or possibly after some of the milder cases of septic arthritis, or gonorrhœa, manipulations may restore the mobility of the joint.

Fractures into and near joints should be treated at first with regard to the fracture, rather than to the joint; complete rest should be afforded for the first week or so, although massage is not contra-indicated, if performed without movements. The first movements permitted are active, as far as they cause no pain to the patient; passive movements, which would irritate the fracture, and cause the production of more callus and adhesions, must not be allowed for the first three weeks, and then not violently or too frequently. Active movement can be encouraged as much as possible when once it has been allowed.

Where we have firm fibrous anchylosis, typically seen in healed tuberculosis, it is no use to expect that manipulations will restore the mobility to the joint Our only indication now is to put the joint in that position in which it affords maximum service in the function of the limb. In the knee and hip joints, when the body is standing vertically and at ease, the joints are both slightly hyper-extended, the line of weight falling behind the hip and in front of the centre of the knee; the hip joint is also slightly abducted. The stable position of these two joints is thus one of slight hyperextension, and, in standing, gravity is an important factor in preventing flexion. Flexion in the knee, and flexion and adduction in the hip, are the positions tended to be adopted in any disease of these joints; these are weak positions, inasmuch as they tend to increase in degree, and militate against the functions of walking and standing; again, these deformities cause relative shortening of the limb, with further deformed conditions of the trunk as a result. Hence we must obtain anchylosis of knee and hip joints in a slightly hyper-extended position; then only will gravity help us to maintain a straight leg. If we are content to have the joints fixed in a position of ever so little flexion, then gravity, on the contrary, assists in the reproduction of the deformity.

Flexion deformities in anchylosis of these joints follow alike, whether the active process has been brought to an end by conservative measures—I am speaking now of tubercle, the commonest cause of anchylosis of the hip and knee-joints—or by erasion or excision. Into the question of justifiability of open operation on tuberculous joints we will not now enter. When flexion deformity has occurred in the hip and knee, it is usual to correct this by osteotomy just above or below the joint. Mechanically this treatment is not ideal; it is always better to correct

deformity at its seat of origin. Although the treatment is not orthodox, many of these old tuberculous joints can be rectified by forcible manipulation, correcting at the site of the old joint cavity, the fibrous tissue easily giving way under pressure, without fear of recurrence of the disease. The limb is then fixed in plaster for several weeks, with the joint in hyper-extension. I have done many of these without evil result.

Further indications, for, and more details of, manipulative processes in surgical treatment will be given in a subsequent lecture.

An Epitome of the alterations in Strength of the Galenical Preparations of the British Pharmacopœia, 1914.

IN a fortnight's time, on January 1st, 1915, the new edition of the British Pharmacopœia will become official, and it is necessary for the medical practitioner to remember that all prescriptions written after that date will be dispensed, unless otherwise ordered, with drugs of the strength indicated in the new official work. That being so, it is urgently necessary that attention should be drawn to the few important changes that have been made.

Fortunately there is only one alteration of extreme importance, viz., tincture of strophanthus, which will be made four times its present strength. Another, but less important change is the alteration in strength of tincture of opium. This is now increased from 0.75 to 1 per cent., so that the increase is 33 per cent., and is appreciable. In addition to its medical bearing, this alteration has a legal importance, for whereas laudanum can now be sold to the public without restrictions, except that the seller must be a qualified pharmacist who must fulfil certain requirements as to labelling, the increase to 1 per cent. brings this article into Part I. of the Poisons Schedule, and it can only then be sold provided the purchaser is known to the seller or is introduced by someone known to both, and each sale must be registered in the Poisons Sale Book.

Generally speaking, the alterations in the new British Pharmacopœia are not important from the prescriber's point of view. They have been necessitated by the adoption of the metric and the renunciation of the Imperial system of weights and measures. For instance, the strengths of preparations have been slightly altered in order to obtain whole numbers, or so that the quantities should add up to 100. Further, in the existing Pharmacopœia the English weights are translated into their exact equivalents of the metric system and the latter are often carried to the second place of decimals. Now that the former have been omitted the opportunity has been taken to round off these inconvenient numbers. An example will illustrate this and show how unimportant these changes are:—the amount of colouring matter—compound tincture of lavendar—in a litre of Liquor Arsenicalis has been rounded off from 31·25 to 30 cubic centimetres.

Aceta.—Acetum Cantharidini of the same strength as the present Acetum Cantharidis has been introduced. All former preparations of cantharides are now made with cantharidin of the same strength, the idea being to secure uniformity and to obtain a wider source of supply. Acetum Ipecacuanhæ has been omitted, and Acetum Scillæ has been increased to double its present strength.

Acida.—The dilute mineral acids have hitherto been of such a strength that equal volumes neutralised the same amount of alkali; dilute hydrochloric acid was 10·58 and dilute nitric acid 17·44 per cent. All these have been altered to a uniform strength of 10 per cent.

Aquæ.—Pimento water and elder-flower water are omitted.

Collodia.—The only change of interest is in Collodium Vesicans, which is now coloured pink with cochineal. Liquor Epispasticus, from which it is prepared, is now made with acetone instead of ethyl acetate, so that it will also smell differently.

Confectiones.—No change, despite the fact that confection of pepper is practically never used, nor is confection of roses, which has now been discarded as an excipient from all the pharmacopœial pills with the exception of Pilula Hydrargyri. Precipitated sulphur now replaces the sublimed in the preparation of confection of sulphur, presumably to avoid the grittiness of the latter-named variety.

Decocta.—The very expensive saffron is now omitted from the compound decoction of aloes. Its inclusion is founded on tradition, and it is also omitted from the compound tincture of cinchona. Decoction of pomegranate bark is omitted, and its place is taken by the alkaloidal mixture called pelletierne tannate.

Emplastra.—On account of the poisonous effects which were occasionally caused by its use, belladonna plaster has been reduced to one half of its present strength. Opium plaster has been omitted.

Extracta.—The green extract of belladonna made by purifying the expressed juice, and the alcoholic extract from the root, have been replaced by a standardised 1 per cent. dry extract made from the leaves called Extractum Belladonnæ Siccum. The corresponding green extract of hyoscyamus is also replaced by a similar dry extract. This, however, is not called "siccum," this term being restricted to distinguish two extracts derived from the same drug. For example, the present Extractum Euonymi Siccum is now called Extractum Euonymi, and to the solid extracts of nux vomica and opium the word "siccum"

is now applied. Extract of male fern is now standardised to contain 20 per cent. of filicin, so that its adulteration with castor oil, which was practised two or three years ago somewhat extensively, will be stopped. Liquid extract of grindelia has been added, and the following deleted—extract of coca, jalap, pareira, calabar bean, sarsaparilla, stramonium, and liquid extract of taraxacum.

Glycerina, Infusa, Lamellæ.—No important change.

Injectiones.—Hypodermic injection of cocaine is reduced from 10 to 5 per cent. As a rule, a footnote calls attention to any alteration in strength, but in this case, apparently by a lapse of editorial vigilance, this is omitted.

Why there should be an official injection of cocaine at all, and not one of benzamine lactate (the new name for betacaine or eucaine lactate), is difficult to understand. Injection of morphine is similarly reduced from 5 to 2·5 per cent. A hypodermic injection of strychnine containing 0·75 per cent. is added.

Linimenta.—The little-used liniment of mercury has been retained, but reduced to three-fifths of its present strength. Opium liniment is increased in strength in the same ratio as the tincture.

Liquores.—The concentrated solutions, such as Liquor Sennæ Concentratus, which were made official in 1898 to render uniform the unofficial concentrated infusions, have all been omitted. They were useful in that they economised alcohol, but in that respect they are inferior to other available preparations. Liquor hydrargyri perchloridi is reduced in strength from 1 in 875 (convenient in that the maximum dose, one-sixteenth of a grain was contained in one fluid drachm) to 1 in 1,000 or one-tenth of a grain in 110 minims. Liquor iodi fortis, the old liniment of iodine of the 1885 British Pharmacopœia, has been renamed Tinctura Iodi Fortis. The imitation Lysol, Liquor Cresol Saponatus can be labelled a failure, because the castor oil soap from which it is ordered to be made, besides being more expensive than the linseed oil product, gives a very milky solution when diluted with tap water.

Lotiones.—Mucilage of tragacanth is now omitted from Lotio Hydrargyri Nigra.

Misturæ.—Creosote mixture and brandy mixture are now omitted. The sugar in Mistura Ferri Composita is now replaced by acacia and glucose. The latter is added as a preservative against oxidation to ferric carbonate. It will be interesting to see how the addition of acacia influences this mixture, because, as a rule, when prescribed in mixtures with insoluble materials, it forms with them hard masses which cannot readily be diffused by shaking.

Pilulæ.—Following the permission to use Socotrine or Barbadoes aloes when aloes is ordered, Pilula Aloes replaces the pills made from these two varieties. Phosphorus pill is reduced from 2 to 1 per cent., and the formula is very appreciably modified.

Pulveres.—Pulvis Elaterini Compositus is omitted. This removes a well-known Conjoint "catch" question as to what were the other ingredients besides the elaterin.

Spiritus.—Spirit of juniper, which is very little used, is now twice its former strength. Spiritus Vini Gallici is no longer a pharmacopœial drug.

Succi.—Three of six are deleted; the only useful one is lemon juice.

Suppositoria.—No change.

Tincturæ.—This class contains the greatest number and the most important changes. As a rule, they have been altered to bring them into line with the recommendations of the International Conference on Potent Medicines. Tincture of aconite is increased to twice its strength. Tincture of belladonna is reduced to seven-tenths its present strength. Tincture of colchicum seeds (name altered to Tinctura Colchici) is reduced to one-half. Tincture of digitalis is reduced to four-fifths its strengths. Tincture of nux vomica is now half strength. Tincture of opium contains 1 per cent. instead of 0·75 of morphine. Tincture of strophanthus is increased to four times its strength.

Trochisci.—Phenol lozenges are reduced to half strength.

Unguenta.—Calomel ointment is increased in strength from 10 to 20 per cent. The two ointments of mercury are about 40 per cent. weaker than formerly. Ammoniated mercury ointment is reduced to half strength.

H. FINNEMORE.

Obituary.

LEONARD PENGELLY WAGHORN.

Killed in action, November 6th, 1914.

Dr. J. W. Waghorn writes :—

Let me, in the first place, thank you for your letter and your kind and sympathetic appreciation of Leonard's friendship with yourself and his other hospital friends. As regards any facts of his life: he was in his 24th year; he was educated at Morton and Vickers' private school at Englefield Green. (Morton was the well-known 'Varsity bowler and was much attached to Leonard.) From there he went to Marlborough. His entry and work at Guy's you know better than I do probably.

He was in the Inns of Court Officers' Training Squadron, and had been promoted to Lance-Corporal. At the outbreak of war he volunteered for service at the front, but was anxious, if possible, to get into the R.A.M.C., and consequently did not avail himself of the opportunities he had of being appointed to some Yeomanry Corps, and perhaps on that account was appointed, to his surprise, to an infantry regiment, the 3rd Battalion (Reserve) of the Royal West Kent Regiment (Queen's Own). Although he was un-

acquainted with infantry drill and duties, he soon made himself an efficient officer at Chatham, and earned the esteem of his Commanding Officer.

He was attached to the Royal Berkshires at the commencement of October, left for France on October the 3rd, was employed on some work near the fighting line in which he had frequent occasion to use his medical training, but where and what the work was he never told us.

On the 3rd of November he joined the Berkshires in the fighting line, and was killed outside his "dug-out" instantaneously by a splinter of a shell on November 6th. In the last letter we had from him, written on the 28th October, he says:—

"It is quite impossible to realise what war means until one sees it; then one sees and hears of such magnificent things being done that they make up for the awful horrors. One thing that no civilian will realise is the absolute and superb magnificence of the British soldier out here. The things that have been done, I am quite certain, have never been surpassed in military history."

The Adjutant of the Berkshires writes me: "He had only been with us three days and we all liked him immensely, and at once knew he was the right sort of fellow to make a good officer."

Second-Lieut. Stokes, who went with Leonard from the West Kent to the Berkshires, but who for some reason was in the fighting line earlier, writes me: "The little time he was spared to us he did awfully well, and you will not be surprised to hear how much he was liked by us all."

1st Berkshire Regiment,
British Expeditionary Force,
October 28th, 1914.

Hope the old Hospital is going on A1. I have been attached to the above regiment. It is pouring with rain, but, thank goodness, I have some tobacco: it is a comfort these days; but everyone is awfully cheerful. L. P. WAGHORN.

Leonard Waghorn entered Guy's in October, 1909, as a London University Student, and I first met him in the Practical Biology Classroom. We had from the beginning a common bond in coming from the same school—Marlborough. I happened to keep in close touch with him during the whole of his life at Guy's, in the Dissecting Room and the Wards, and he was one of my dressers from April to June of the present year. This was the last appointment he completed, for in August he volunteered for service while holding the appointment of Senior Medical Ward Clerk. I had a letter from him in September, when he was stationed at Chatham, in which he regretted his inability to join the R.A.M.C., and the post card, written on October 28th, which is printed above. As a student he showed considerable promise, particularly since he entered the wards. He worked hard, always doing his full share of the more tedious work inevitable in each appointment. He had skilful hands, and promised to turn out a neat and deft operator. All his teachers thought highly of him and appreciated him.

With his bright, sunny disposition, his frank, open face, he was a most lovable man, and one who was deservedly popular with all whom he had any dealings with. In him Guy's has lost one of her sons whom she could ill spare. It was with great grief that those of us, who loved him, read the announcement that he had been killed in action. But with our grief was mingled a feeling of pride that he had died the glorious death of a soldier fighting for his King and Country in a righteous cause. E. C. HUGHES.

Analgesia.

A Paper read at the Opening Meeting of Guy's Hospital Dental Society, Session 1914—15, on November 3rd, 1914, by L. S. PILBEAM.

MR. PRESIDENT AND GENTLEMEN,—The administration of gases and mixtures of gases, and the consequent effect upon the blood and nervous system causing total or partial loss of sensation, is a subject which, though most important to the dental profession, does not appear to have received that recognition which it undoubtedly deserves.

It is well known that good dental work often entails severe pain, and to avoid giving pain a cavity is often not cut in the orthodox manner because a tooth is so sensitive, and this, no doubt, accounts for much of the unsatisfactory work which from time to time is brought under our notice.

I submit that many conscientious men, rather than do unsatisfactory work, suffer their patients to bear severe pain; with the result that we have closed the door upon many nervous people who would be our patients but for the pain which one of their friends suffered in the dental chair. Moreover, to inflict pain on a patient has its reaction on the operator: it is a strain on his nervous system conducing to fatigue and subsequent irritability.

Therefore, gentlemen, you will agree it is most desirable that pain such as that caused by cutting sensitive dentine or the opening of an abscess should be eliminated from dental operations, so helping us to give orthodox treatment and consequent better satisfaction to our patients with less strain to ourselves. The judicious administration of certain gases makes such operations painless and will, in the future, dispel all fears of the dental chair. Before the condition of anæsthesia is attained two other conditions are experienced by the patient: the first, a period in which the patient is said to be analgesic; and the

second, in which excitability is the predominating feature. With a patient in the condition of analgesia one may perform all the everyday dental operations satisfactorily without pain.

Analgesia is a condition in which the blood is so changed as to cause partial central and total peripheral inhibition of the nerves so that sub-cutaneous stimulation that would normally cause pain gives rise to no discomfort; the senses of smell and taste are abolished, but tactile sensation and speech are not denied, and hearing is intensified, whilst optically, myopia is present with slight magnification of objects within range of vision. The mental condition is such that the patient is in a state of contentment, which is a more satisfactory and pleasurable feeling and quite distinct from that of happiness, which is a form of excitement, to which there must necessarily be a reaction.

To administer a mixture of nitrous oxide and oxygen skilfully it is necessary that the apparatus used should be thoroughly understood, practical personal experience being the only way to obtain good results. Essentially the apparatus for the maintenance of analgesia consists of a supply of nitrous oxide and a supply of oxygen which can be easily and thoroughly mixed and which can be administered in any proportion.

The Clark apparatus is simple in construction and easy to manipulate. It consists of two rubber bags, one for nitrous oxide and the other for oxygen, fed from respective gas cylinders. Complete expansion and thorough mixing of the gases is ensured, the proportion administered is governed by one lever, whilst automatic regulators minimise the pressure of the gases allowed to escape from the bags. The gases, when mixed, traverse three feet of tubing to a nasal inhaler, which is provided with an air regulator and exhalation valve; the light aluminium disc in the latter makes a ready response to the quietest breathing, closing on inspiration and opening on expiration. The whole apparatus (which is capable of carrying a spare cylinder of each gas) is mounted on a stand (some three feet high) provided with castors, making it easily movable, compact, and neat in appearance.

Before each administration both gas bags should be inflated equally, and a mixture of 50 per cent. nitrous oxide and 50 per cent. oxygen allowed to escape till the bags are almost collapsed, ensuring minimum pressure and at the same time eliminating all stale gases remaining in the apparatus from previous use. The bags are kept in this condition, only sufficient gas being taken from the cylinder as is necessary for the patient's consumption. During administration the air regulator of the nasal inhaler should be closed to prevent the admixture of air, and the exhalation valve should be allowed to open fully so that the used gases may escape, thus eliminating re-breathing which is undesirable by reason of carbon dioxide accumulation.

The suroundings in the room should be of a quiet and restful character, and absolute silence maintained; the latter is essential, too much stress cannot be laid on this matter, it is of paramount importance; the patient is not to be disturbed by any external noise whatsoever. The temperature of the surgery should be about 70° F. if it is desired that the mixture should be more rapid in effect; a low temperature should be avoided as excitement is produced, possibly accompanied by nausea, and the patient is less easily controlled.

All types of people present themselves for dental treatment, but for analgesic purposes they may be divided into four classes :—

1. The alcoholic.
2. Nervous and easily excitable.
3. Susceptible.
4. Non-susceptible.

With the first class, the alcoholics, care must be taken to avoid inducing the stage of excitement.

The second class, the nervous, should be made thoroughly accustomed to the apparatus by breathing air only with the nasal inhaler in position for a considerable period. To obtain the confidence of the patient is difficult in many cases, but must be accomplished; the use of mental suggestion is important and the induction of analgesia should be extended over a longer period than usual.

Anæmic individuals are easily controlled and require a smaller percentage of nitrous oxide, and are so termed susceptible.

Non-susceptible patients are those whom it is more difficult to bring under the influence of the gases and who require a higher percentage of nitrous oxide for the requisite condition.

It is not wise to subject a patient to the condition of analgesia immediately after a meal as nausea may result. Nevertheless, it is injudicious to mention this fact to the patient as such a statement may alarm him. It is better to arrange to see such patient to whom one intends to administer the mixture for analgesic purposes between the hours of 11 and 1 midday and after 3.30 in the afternoon. Tight collars and neck bands should be loosened, and though this is not an essential detail, attention should be directed to the matter, especially with stout patients to gain comfortable relaxation.

For analgesic purposes the patient should be seated comfortably in an upright position ; the head, though supported, should be brought forward to allow the saliva to be satisfactorily removed by the ejector; to permit saliva to pass backwards is to risk a nauseating effect and to impede normal respiration.

It is admitted that mental suggestion is an aid when administering gases, and this is especially the case when nitrous oxide and oxygen are used to induce an analgesic condition ; also that such a thing as a subconscious mind is existent is proven by the fact that in trying to recall someone's name we are unable to

think of it, though it is on the tip of our tongue, as we say, but when thinking of something else quite different it comes to us, so to speak, which is indicative of a subconscious mind, over which we ourselves have not absolute control. It is to this subconscious mind, which is prone to suggestion, that one appeals when offering mental suggestion to a patient in obtaining their confidence by assurance that they will find the effect of nitrous oxide and oxygen most agreeable, that the tingling, a truly curious sensation, is necessary, that there is nothing to fear, that he will feel no pain and yet be conscious.

It is just a matter of holding a patient's confidence and putting him entirely at ease under conditions which are unusual to him. Each dental surgeon has his own way of doing this according to the type of individual with whom he has to deal.

Prior to administration tell the patient to blow the nose to clear the nasal passages, then the nasal inhaler, with the air regulator open, may be applied and the patient allowed to breathe air only through the nose that he may become accustomed to the apparatus.

When this is accomplished, mention that you are going to give him some nitrous oxide and to let you know when he feels abnormal—a slight tingling or numbness—then turn the lever controlling the gases to pure nitrous oxide and close the air regulator, taking care to see that the inhaler is closely applied so that no admixture of air is possible. Your patient is now breathing pure nitrous oxide, and in six to nine breaths or 25 to 35 seconds—the period varies according to the type and consequent susceptibility of the patient—he will mention that he feels abnormal and has a tingling sensation. This is the analgesic condition, and for its maintenance it is necessary to replace a certain quantity of the nitrous oxide by oxygen—the percentage of oxygen necessarily varies to a slight extent with different patients, but the average amount is 20 per cent. The requisite percentage for the individual having been ascertained, induction is complete within $2\frac{1}{2}$ minutes of the commencement of administration.

At this stage one or more of the signs of analgesia will be apparent. Tingling or numbness is experienced and perspiration on the forehead may be apparent. The patient feels no pain on biting his own fingers, and on closing the jaws the teeth seem as if made of wood. The pupils are slightly dilated.

Once a patient is analgesic it is of great importance to keep him so till the operation is finished; an irregular analgesia is very liable to result in nausea and subsequent headache.

With alcoholic patients it is found necessary to use pressure in administering the mixed gases with a lower percentage of oxygen, whilst patients over 50 years of age require a greater percentage of this gas.

When analgesia is maintained for periods over 15 minutes, it is usually necessary to increase the percentage of oxygen. Patients may become drowsy, but must never be allowed to close their eyes to sleep or become unconscious; if the tendency is irresistible, the patient is having too much nitrous oxide. To open the air regulator a little will overcome this tendency if the colour is normal, but if the patient is pale more oxygen and less nitrous oxide is necessary to restore the colour while the analgesic condition remains unaltered.

Laughing is co-incident with excitement, a condition too deep and unsatisfactory both to dentist and patient. Any tendency to laugh is indicative of more oxygen than is necessary, and is overcome by increasing the percentage of nitrous oxide. Should a patient recover slightly through the injudicious or accidental admission of air, pain may be felt; there is no need to ask if he suffers pain, it will be clearly indicated on his face. He should be told to smell strongly, at the same time giving a temporary increase in the percentage of nitrous oxide.

The patient should be allowed to recover by breathing air and not by increasing the amount of oxygen as hitherto practised, as the latter tends to excitement and nausea. Rest in the chair for two or three minutes after recovery should be permitted, and any perspiration bathed from the forehead. This has a refreshing effect which may be enhanced by the use of Vaparole, a preparation by Burroughs, Welcome & Co., consisting of aromatic ammonia, hermetically sealed in a small glass capsule surrounded by cotton wool, enclosed in a silken sac. This can be easily broken between the fingers and the vapour of the contents inhaled.

With nitrous oxide and oxygen it is possible to maintain analgesia for a period of two hours or more, and the average quanitity of gas used is nearly two gallons of the mixture per minute at a cost of just over 1d. The oxygen in nitrous oxide is not free, therefore the blood is unable to obtain any oxygen from it.

The percentage of nitrous oxide in the lungs rises with each breath, and at the same time the oxygen in the blood is converted to carbon dioxide and exhaled, whilst nitrous oxide enters into combination with the hæmoglobin, and should administration be continued, cyanosis will occur, secondary to the displacement of oxygen in the blood by nitrous oxide.

When analgesia is produced, only sufficient oxygen is given to the patient to enable the blood to form the necessary oxy-hæmoglobin to keep the colour normal. The effect of this change in the composition of the blood is that certain centres are suppressed: the first is the sense of smell; this is followed by taste; next comes relaxation of the ciliary muscles of the eye producing myopia; appreciation of cutaneous painful stimuli is abolished, the pupil dilates, and, lastly, hearing is intensified. Tactile sensation remains. Pulse rate and respiration are increased, but regular,

whilst a slight giddiness and difficulty to maintain equilibrium is evident on standing up. Mentally, there is a feeling of supreme contentment, though one's ideas are distorted, and there is marked inability to concentrate the mind on any subject. One really feels that it is too much trouble to do anything or to think of anything, and yet the presence of contentment makes the mental condition ideal. It is a condition of intoxication, a state of disordered consciousness; you just feel that you don't care what happens so long as you can keep in that condition.

Experimenting with varying percentages of these gases, I have found that by increasing the percentage of oxygen by 10 and decreasing the percentage of nitrous oxide by 10 at a time a change of condition is noticed when breathing a mixture of 60 per cent. nitrous oxide and 40 per cent. oxygen. Vision is cleared, equilibrium is better maintained, while the face presents a slight flush. With equal percentages of each gas there is an inclination to laugh, while later with the oxygen at 60 and 70 per cent. and nitrous oxide at 40 and 30 per cent. respectively, we have the commencement of excitability and the desire to laugh is almost uncontrollable. All thoughts and ideas seem to have a humourous aspect. Increasing the percentage of oxygen to 80 and 90 and then pure oxygen, the face becomes increasingly flushed, with recovery from analgesia and a feeling of nausea.

Reversing the experiment and commencing with pure oxygen and replacing it by nitrous oxide 10 per cent. at a time, at first a sense of warmth pervades the whole body, then slight tingling and perspiration. This is a light analgesia which pure oxygen is capable of producing. With 40 per cent. nitrous oxide and 60 per cent. oxygen deep analgesia is obtained with the commencement of excitability which increases till 60 per cent. nitrous oxide and 40 per cent. oxygen is being breathed, when excitability passes off, anæsthesia being produced with the mixed gases containing 90 per cent. nitrous oxide.

Tabulated, these results may be better compared :—

	Nitrous Oxide.	Oxygen.	
Exp. I.—	80	20	Analgesic.
	60	40	Vision clearer; eqilibrium more stable; slight flush.
	50	50	Inclined to laugh; condition of light analgesia.
	40	60	Commencement of excitability; great desire to laugh: all ideas seem humorous.
	30	70	
	20	80	Very flushed.
	10	90	Recovery,
	0	100	Feeling of nausea, due to irregular percentages of gases administered.

	Nitrous Oxide.	Oxygen.	
Exp. II.—	0	100	Tingling, sense of warmth, perspiration: condition of analgesia,
	10	90	
	20	80	
	30	70	Slight excitability.
	40	60	
	50	50	
	60	40	Pronounced excitability.
	70	30	
	80	20	
	90	10	Anæsthesia.

Perspiration may be produced by the use of nitrous oxide only, and as seen in Experiment II., also by oxygen only. Hence the perspiration produced on the forehead in analgesia cannot be ascribed to lack of oxygen, but to some specific action on the sweat centres which is possessed by both nitrous oxide and oxygen.

The danger when administering these gases is practically nil, and an assistant is not required. After effects are nil when the analgesia is regular, but if irregular, vomiting is very liable to occur.

Though the mixed gases escape at a temperature of 65° F., it is considered by some to be advisable to heat them, the reasons being that a warm gas—

1. Is less likely to irritate a sensitive respiratory tract.
2. Is more effective with an alcoholic patient.
3. Shortens the period of induction, which has obvious economical advantages.

Accordingly provision has been made for the mixed gases to be slightly heated by an adjustment which may be used or dispensed with as desired. With these gases it is possible by slow induction to enter upon the third stage of anæsthesia without the excitable stage being apparent, and this, too, with but little warning.

A patient becoming "tired," as they will tell you, or drowsy, develops a tendency to close the mouth, making it necessary to use a metal saliva ejector in place of the more usual glass type, for should the patient close the jaws firmly together, a glass ejector may be broken in the mouth and unpleasant complications ensue. The "tired" feeling is dealt with by decreasing the percentage of nitrous oxide and automatically increasing the percentage of oxygen.

Some operators use a prop to aid the patient in keeping the mouth open, but in preventing the patient from closing his mouth it is seen that he may pass unobserved to a deeper stage than is necessary or desirable, for should this take the form of excitement, operating must be suspended till the patient is analgesic again, besides the risk of nausea through irregular analgesia.

When working under analgesia, the patient, being partly anæsthetised, does not expectorate débris unless

told to do so. The accumulation of débris in the mouth, together with mucous in the throat, may have a nauseating effect. Accordingly the patient should be told to expectorate such débris from time to time and bearing in mind that the patient is somewhat helpless, a hand spittoon should be used.

A nostril inhaler is preferred by some operators, the mixed gases being conveyed to the nasal passages by two tubes, one in each nostril. The advantage claimed is that it does not admit of any unintentional admixture of air to the gases. However, mucous is liable to partially choke the tubes during administration, and many patients do not like its use.

It has been said that music is an asset when inducing analgesia and anæsthesia ; admitted that soft, melodious music is conducive to calm and peaceful anæsthesia, but for analgesia I would emphasise again the necessity of absolute silence.

Other methods of eliminating pain from dental operations are many in number, but the majority are inadequate with our requirements and are of such little use that they become tedious in practice and our patients tire of their application. An example of this was afforded to me a short while ago. A patient attending the hospital was suffering intermittent pain in connection with a maxillary second premolar, due to periodontitis and chronic pulpitis. Several sedative dressings had failed to assist the dresser to open that pulp chamber, and the patient was tiring of presenting herself so many times for the treatment of one tooth. Under analgesia the pulp was opened, its contents removed and antiseptic dressings applied in the roots and sealed, without pain to the patient, in fifteen minutes.

For the removal of pulps it is usually necessary to actually anæsthetise a patient for a brief period, induction and recovery being so slow as to be unnoticed by the patient. However, in the case mentioned the pulp had partly suppurated so that such a course was unnecessary.

It may not be out of place to here mention a few of the practices now in vogue to facilitate the preparation of a cavity.

Important factors in the prevention of pain are the use of sharp burs and excavators with only sufficient pressure for cutting purposes, and the application of rubber-dam to keep the cavity dry.

The repeated application of carbolic acid and menthol with the hot blast, or the use of zinc chloride, are helpful, but both are tedious to work with, and the latter is very painful when applied. A 20 per cent. solution of silver nitrate is used, but this is also painful, and, further, may stain the tooth, which is undesirable, and can accordingly only be used at the back of the mouth. Oil of cloves and dressings of zinc chloride and eugenol are of use in many cases, but again are tedious in a busy practice where time is valuable. Dressings of paraform in combination with zinc chloride made into a paste with carbolic acid and menthol are often unsatisfactory, the formalin in paraform being an irritating drug, sometimes giving much pain subsequent to its application.

The injection of cocaine into dentine with the high-pressure syringe has received some favour. A pit is made in the dentine with a spear-head bur and then as much as a 10 per cent. solution of cocaine is injected, pressure being maintained for at least a minute. The hypodermic needle used is blunt at the end and so fits accurately into the conical pit. Whether the cocaine travels between the dentinal fibril and Neuman's sheath or forces the fibril out of the tube into the pulp has not been determined, but that the cocaine travels via the dentinal tubes and anæsthetises the pulp is an established fact, and good results are obtained, but its application in some situations is fraught with no small difficulty.

Many dental surgeons use an hypodermic syringe for local injections into the periosteum and bone to desensitise the tooth. There are four ways of accomplishing this :—

1. Drilling into the cancellous bone of the alveolar process, with injection into the bone direct.

2. Injection into the periosteum of the bone diffusing through the bone to anæsthetise the periodontal membrane.

3. Injection into the periodontal membrane direct, by guiding the needle up the side of the tooth till it reaches the periodontal ligament.

4. Injection into the soft tissues at the site of the sulcus immediately above the apex of the tooth upon which one intends to operate.

The anæsthetic generally used is a $1\frac{1}{2}$ per cent. solution of novocain in normal saline. Though these injections are efficient in many ways, this method of treatment is not applicable in patients suffering from pyorrhœa alveolaris, nor is the anæsthetisation of the tissues injected without discomfort to the patient. Further, when injecting near the mental foramen it sometimes happens that one also anæsthetises half the lower lip, which is distinctly annoying and disconcerting to the patient.

With somnoform vapour, as with nitrous oxide and oxygen, one is able to not only desensitise the tooth, but to obtain a general peripheral inability to appreciate painful stimuli; especially useful for opening an alveolar abscess, another instance where a local injection is inapplicable.

Somnoform is a mixture of ethyl chloride, 60—83 per cent.; methyl chloride, 35—16 per cent.; ethyl bromide, 5—1 per cent.

It is administered with a large proportion of air; for some four to five inhalations a mixture of one-eighth somnoform and seven-eighths air is given, and then one quarter somnoform and three-quarters air till there is a lazy dropping of the eyelids and slight muscular relaxation; the somnoform is then shut off

for about five breaths, the patient now being analgesic, and then only sufficient is used as is necessary to keep the patient in this condition. The patient becomes pale, perspiration breaks out on the forehead, and dilatation of the pupils is apparent. Though efficient, the constituents of somnoform are dangerous, and call for skilled administration. It is not possible for one man to safely give this anæsthetic and operate as well.

In practice a dental surgeon usually gives his own anæsthetic only in emergency, though his dental qualifications include the administration of anæsthetics. By law there is no restriction on anyone giving an anæsthetic to another, if with the latter's permission, but a man holding medical or dental qualifications is debarred from giving an anæsthetic for an unqualified person; neither may he allow an unqualified person to give an anæsthetic for him. In court of law, in a case of accident, it is probable that experience in the administration of anæsthetics would be given preference to qualifications.

Nitrous oxide has an action on the sexual organs which chiefly affects patients of the nervous and susceptible types, and for this reason it is best to invariably have another female in the surgery when female patients are being treated under anæsthesia and possibly when only analgesia is induced, to avoid unpleasant allegations of violation.

I do not advocate the use of analgesia for hospital work, but for use in private practice where so much depends on our ability to do satisfactory work without pain, it is my humble opinion that instruction in this subject and also, incidentally, on radiography, should be included in the hospital curriculum, for there is no doubt that these subjects have a great future, while it is difficult to commence their study in private practice.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—May I bring to your notice the enclosed letter from Miss de Laveleye and Miss A. M. Fletcher who are appealing to friends and sympathisers for subscriptions to enable them to buy an X-ray apparatus to take back with them to their hospital in Ghent as soon as the Allies re-occupy the town.

By special permission from the Superintendent, Miss de Laveleye and Miss Fletcher will study X-ray work at Guy's, and letters enclosing subscriptions may be addressed to them at the Hospital.—Yours faithfully,

L. V. HOUGHTON,
Matron.

Matron's House,
Dec. 13th, 1914.

London,
Dec. 14th, 1914.

Dear Matron,

We have just returned from Ghent, and think you might be interested to know something of our life there since the beginning of the war.

For the last two and a half years we have been working in a private hospital which, at the outbreak of the war, was offered to the Belgian Government for the wounded soldiers. Up till the time when the Germans entered Ghent we were continually receiving men sent on from towns nearer the fighting line which were being evacuated; but when the field of activities reached the western side of Brussels — Alost, Termonde, etc.—the wounded were sent to us straight from the battlefield.

At an early hour of the morning, on the day of the Germans' entry into the town, all the wounded soldiers had to be hurriedly sent off to the coast, with the exception, of course, of those who were absolutely unfit to travel, three of the latter being left to us at the Institute. Of these, two were British and one Belgian. Unhappily, after four days, we lost one of our Englishmen, an officer, who succumbed owing to severe abdominal wounds. The Belgian, as soon as his condition would allow of it, was removed to the Civil Hospital, where he was skiagraphed and underwent a second operation. Thus, we were left with one patient, as far as the soldiers were concerned, a man who was wounded at the siege of Antwerp, having received eleven shrapnel wounds.

For the first few weeks after their arrival in Ghent, the Germans left our Englishman unmolested. We had some German officers and their orderlies quartered on the ground floor of our Institute. We were, of course, cut off from any communication with the outside world —no letters, no papers, except those under German censure, no telephone, or telegraph.

Ghent soon became one of the most important towns near the field of battle, and the amount of war material that passed through to the front—motors, guns, aeroplanes, petrol tanks, ammunition, etc., not to mention horses and men—is indescribable.

For the first few days after the German occupation we could hear the roar of the cannon almost incessantly; then it died away, and how we longed for it's welcome sound again telling us that the Allies were approaching!

Our unwelcome guests on the ground floor were replaced, after about a fortnight, by some German wounded officers with German nurses to tend them.

Then, as the German wounded were pouring into Ghent by trains' full at a time, a large room on the first floor was also occupied by them.

We were not, however, to remain undisturbed. One evening, when we had had our British soldier with us about five weeks—a man who was still suffering a great deal, but whom we hoped to pull through—two German doctors suddenly entered our Institute, followed by Red Cross men carrying a stretcher. They told us that they had orders to take our Englishman immediately to the Military Hospital.

Not long after this the German authorities commandeered the whole of our nursing home and equipment, so, for the time being, our work was at an end, and we managed to get through to England. This private hospital was built only some three and a half years ago and is very well arranged and up to date. The operating theatres are excellent, being large and fitted up with all the latest improvements. Notwithstanding this, in our recent work with the wounded we have found that there is one thing of vital importance lacking—an X-ray apparatus, which, one need hardly point out, is very necessary indeed.

Under the present circumstances it is impossible for the Belgians to provide such a costly apparatus, so we appeal to you most earnestly in the hope of gaining your help towards raising the sum of between £150 and £200 for this object. Would you be kind enough to make our appeal known through the medium of the Hospital GAZETTE, so that we might enlist the sympathy of it's readers We should be very grateful of the smallest contributions which can be addressed to us at Guy's Hospital. With many thanks, Yours gratefully.

A. MAUD FLETCHER.
M. E. de LAVELEYE.

DEAR SIR,—The occurrence of diabetes in members of the same family has, I believe, often been recorded, but it may be of some interest to mention another example. Last week I was called to a lady visitor, aged 25, in a state of diabetic coma; her urine contained 35 grains of sugar to the ounce and gave very definite tests for diacetic acid and acetone. I treated her by liberal transfusion with saline and 2 per cent. sodium bicarb. There was a temporary rally, followed by death 36 hours after the onset. Some two years ago two younger brothers of this patient died from diabetic coma. The disease in each case was said to have started after a severe fall on the head, and a month ago a first cousin also died from diabetes.—Yours, etc.,

Carlyon, Shanklin, Isle of Wight,
Dec. 2nd, 1914.

J. A B. HAMMOND.

DEAR MR. EDITOR,—May I trespass on your space to correct a misstatement in my article on "Diagnosis of Gastric Conditions by Chemical Methods" in the last number of the GAZETTE Cases of gastric and duodenal ulcer occur, though relatively rarely, in which there is neither hyperchlorhydria, nor hyperchlorhydria masked by regurgitation. The hydrochloric acid of the stomach contents may even be much below the normal value.—Yours faithfullly,

J. H. RYFFEL.

DEAR SIR,—A new edition of the Guy's Hospital Pharmacopœia is being prepared. The Committee who are doing this will be grateful if old Guy's men, whether medical or dental, will send to me, for consideration by the Committee, any prescriptions or formulæ, or the names of any non-pharmacopœial drugs which they suggest it might be useful to include in this new edition; indeed, any criticisms or suggestions would be welcome. Yours faithfully,

W. HALE WHITE,
Chairman of the Guy's Hospital
38, Wimpole Street, W. Pharmacopœia Committee.
12th Dec., 1914.

DEAR SIR,—Long has mine eye been offended by, and my mind agitated by the get-in-the-wayness of the nurses' veils. Away with them! How on earth have they lived so long! Bart.'s and other sensible hospitals forbid them, and so would—Yours

"SINCE THE EARLY SEVENTIES."

Nursing News.

MATRON'S OFFICE.
Nairobi,
Nov. 2nd, 1914.

Dear Matron,

Your very interesting letter reached me last week, and was very welcome indeed. It seems as though our little skirmishes here were hardly worth mentioning when so much is happening in Europe, but even here one could write pages about the various engagements. I have heard first-hand accounts of every engagement except one (Gazi), and I got that second-hand from a young K.A.R. officer who was passing through Mombassa a few days after and heard what happened from his friend who was one of the wounded. The wounded from Gazi all went to Mombassa 30 miles away, all the others have been brought here, but there have not been many. The Germans don't let the wounded escape; only those who can ride away escape.

The first wounded man we had was a scout called Goodwin quite at the beginning of the war, but most of our patients are dysentery and malaria cases, who get well very quickly. We are expecting a large number of wounded hourly now, as the attack on Longido is in progress.

I had such an interesting experience—the S.M.O. of the Magadi district took me to inspect a base hospital there. I went down in the hospital train and visited the hospital, and the next day I went in the Red Cross Ambulance to Bissel Camp, sick outpost about 55 miles from German East Africa. From there some officers took me in a motor five miles nearer while the ambulance went on to Douniosok with the S.M.O. on board. I might have gone, too, but I decided not to as the country is so rough that a breakdown was almost inevitable, and I didn't want to be hung up and not able to return here. As the ambulance rode off, Captain ———, who was with me, said under his breath, "we've seen the last of them." Meanwhile we climbed a mountain and got a most interesting view of German East Africa, of our camp at Orok (where we have 350 men), of Longido (where a strong party of Germans are entrenched). I was shown where the Ingito Hill engagement took place, where 32 of our men attacked 200 Germans at a distance of 40 yards. Ten of our men were killed—or murdered—and 24 wounded, and the Germans about the same number. Our wounded were shot at close range and later bayonetted by the native soldiers. The two who got away came here and have done very well. They met a lion when they were being brought in. The men say they could see nothing except the flashes from the rifles at a distance of 40 yards, the thorn bushes are so thick. The enemy had two Maxims.

Then we have had the Ross Commandant and his two sons here; also some German prisoners from Kisi. Mr. Grey, too (Sir E. Grey's brother), who lost an arm there, has been among our patients. The great surprise here has been the K.A.R.'s (native soldiers). We did not expect much of them, but they have done splendidly. At Isarvo, when Mr. Oldfield was wounded they threw themselves over his body to try and protect him, and were found riddled with bullets. At Gazi all the officers were wounded, and the black sergeant led them against tremendous odds and drove the Germans over the border. Both there and at Kisi the Germans left stores and ammunition behind them. At Burra they left their dead, and some very valuable maps were found on a dead colonel, showing water holes where we thought none existed, also the road to Nairobi marked in red ink. Our men are very brave.

The men say that the Germans are getting very short of ammunition, but it is thought that they have landed the guns from the "Konigsberg." No one can imagine why the Germans delayed attacking us here. We had no guns, and would have been quite defenceless till about three weeks ago when several thousand troops came from India with guns. We are pretty full here now. I try not to look ahead, because we are not allowed to organize for the large numbers who will be sent here. I can only hope that some miracle will happen and that we shall worry through as we have so often before.

I have got nearly everything I asked for—the new sanitary buildings for one end of the hospital are above the ground. The other, I am afraid (where they are most needed), have been blocked. Out of the six sisters I found here, four have been drafted off to base hospitals, etc.

Everything seems so odd here. One probationer arrived with her black servant, which would astonish most English matrons. It seems odd to have only one nurse and one probationer on duty for 50 patients, but the work is so different from an English Hospital—there are so many servants.

I am so grateful to you for looking after Boy's moral welfare. I often think of him and wish he were here. There were endless dogs and cats when I came here, but only one remains, and he is half a jackall. He followed an Englishman hundreds of miles from Abyssinia, but he is, after all, half a savage. There was a cat here, also half wild, with two kittens, and they were given by two Sisters to separate people. An awful quarrel ensued, and a third Sister, who was on night duty, settled the matter by chloroforming all of them.

The person I like best here is my servant; he washes my clothes, cleans my rooms, waits at table, caddies for me when I play golf, runs after me when I bicycle in the dark, cleans my bicycle, and generally plays guardian angel. He speaks a little English, and so is useful as interpreter when I get into difficulties. Some of the native servants are such nice clean people. I like them immensely. They are most of them C.M.S. Mission boys, and they really work very well. My boy Ali runs after me with a parasol if he thinks I have forgotten it, and is always doing thoughtful things.

———

November 4th.

I went for such a nice ride this afternoon across the plains. The game is so tame, we rode right amongst herds of zebra, wildebeaste, congoni, etc. We went as near to the wildebeaste as we cared to, for they are very like buffalo and very dangerous. There has been some rain, and the plains were quite green and easy for the horses to galop on. Everyone here rides astride; I am quite used to it now. The snow-clad mountains are showing up well just now.

I enclose a photo I took at Kajiado which may interest Miss Smith. I have just heard that several Englishmen have been killed and wounded at an attack on Longido, but we do not know the names yet. They say the war will be over here in three months.

I have written a very long letter—I hope not too long. I hope you had a good holiday. With kind regards to Sir Cooper, yours sincerely,

M. ATKEY.

Letter received at the Institution from Nurse Ames.

No. 8 Clearing Hospital, etc.,
November 29th, 1914.

Sister Kiddle, Fraser, Shackleton, and I, with one Q.A., have been sent here to a clearing hospital. It is a great stroke of luck, and we are very much pleased. The little town is absolutely full of soldiers and transport waggons. The latter fill the little streets and squares, and the soldiers sleep in some of them and make fires in the streets; it is so picturesque.

We are only five miles from the firing line, so do not keep the men more than 12 to 24 hours unless it is absolutely necessary. We are using a school as a hospital, the chapel of which is also used as a ward. We have not many beds, but lying down room for 400. We are billeted in the most delightful quarters. It is a Roman Catholic Orphanage for little girls, kept by two maiden ladies. We sleep in the dormitory in cots with white curtains! We have meals in the school room. It reminds one of the school in "Quality Street." Everything is very small, especially the washing apparatus, but also the tables and chairs, etc. The dormitory is a great big loft with great beams, but beautifully clean.

We had a great rush to get off from Versailles; at the last we only had about half-an-hours's notice. We were driven into Paris by motor car to the Gare du Nord in about 35 minutes; then we took all day to get to Calais, arriving there at 10.30 p.m. All the hotels were full up, so we had to sleep in the station, like a number of other people.

Received at Matron's Office.

The Convent,
France,
(Expeditionary Force),
Dec. 7th, 1914.

I promised to write and tell you about everything when I got abroad, so as we are still waiting for patients and there is some spare time, I may as well write whilst there is still time. I must say that I had no idea that we were not intended to nurse our own "Tommies," otherwise I should have been quite contented to stay in England.

At any rate, we landed at St. Malo and were starting there and then for a place called Tréguier, but were stopped at the last moment by a Sir Maurice de Bunsen who had come over on our boat and who had been sent over by the British War Office to investigate and report on the hospitals here, so we had to stay for about four days at Paramé, near St. Malo, so it was not till the Monday morning (just a week ago) that we came on here. To our amazement we found we were coming another 100 miles *away* from the fighting line, being already from 200 to 300 miles from it at St. Malo.

After a long tedious journey, part of the way in very primitive carriages, not at all suited for transporting the wounded, we arrived at this Convent, which is transformed into a hospital. The water supply and sanitary arrangements are conspicuous by their absence. One block, where there are about 100 beds intended for surgical patients has neither lavatory nor water! Why do they not send women who are fully trained to investigate these matters with the men, who evidently do not realise how important these matters are? In the *medical* block, quite a long way away up two steep and awkward flights of stairs are *the theatre* and 100 more beds. There is certainly water, but no means of heating it, and two most terrible lavatories which have to be closed up for *three days* each week to be cleaned out.

We are undergoing this ordeal now. It is bad enough now, but I cannot think what it will mean when the beds are full. There is one bathroom somewhere outside where the soldiers are to be bathed when they arrive, but there is no water supply to it and no means of emptying it. The problem is how we are to wash our patients, or how we are to dress their wounds with no means of washing our hands or boiling water. Already installed are three French doctors who speak no English and two English doctors who speak no French, and we are hundreds of miles from the front, and how to get the wounded here is another problem.

True, there are wounded already here at another Convent, but their wounds are not serious. Many of them have bullets still inside them, which the doctors leave there. This other Convent, which is turned into a hospital, is run by the French Red Cross with nuns and V.A.D.'s (French). We went round their terribly overcrowded wards one day, and were everywhere assailed by the stench of stale urine. It was just terrible. But there comes, again, the need of better sanitary arrangements. I should not think any of the utensils were ever washed.

We hear that the wounded may come at any time. In the meantime we are waiting for them. We are really in Brittany and not far from the coast, to which most of us took a long walk a few days ago, doctors and all, and picniced on the rocks. It was glorious, the sea deep blue, with the water dashing and swirling about the rocks which stood far out into the water. Tréguier is a typical little Brittany town reached by a most primitive railway and containing a beautiful little cathedral, and quite a large river. There are several convents. We give them no trouble but the preparing of our meals and the washing of our linen. The meals are served in a long dark dining room, and they are always cold. We make our beds, clean our rooms and fireplaces, and attend to our own fires, even making our own arrangements about the supply of wood and coal. I think the dear old nuns

think our fires are unnecessary luxury (they, poor things, never see one), and appear to object to their presence. It has rained ever since we came here, so it really feels very cold and damp. None of the wards are heated at all!

The men, apparently, get into bed with all their clothes on. It appeared to be the custom at the other convent. We get a sheet once in three weeks, and the patients are to have one once a fortnight. There are no clothes beyond a cotton shirt and a pair of socks for the men when they come, which are all laid out on their beds getting damper and damper each day. For baths we have to go to an hotel in the town. It is the only bath in the place, but they say it is quite nice. I haven't been yet, as I manage to get quite a respectable bath in my basin.

I must say I thought I was being sent to France where the really badly wounded were, and instead of that I am here where we shall get only hands and feet, and there seems a great uncertainty as to whether they will come or not. And, again, I cannot see whatever in the world they wanted to start another hospital when there is one in the town which could accommodate all the wounded they could get here. It's a tremendous waste of public money, I consider.

Red Cross in Russia.

A GREAT building surrounds a gloomy but large courtyard, or rather two courts, into which the winter sun seemed never to get—at least after mid-day. An archway at either end formed the only entrance, and the small windows of a half-sun basement revealed on Sunday peeps of the family life of orderlies who had accompanied their wounded masters back from the front. Inside the court an occasional door gives admittance to the foot of a staircase, where an orderly demands your name and business; if satisfied, he proceeds to take your overcoat, hat and stick, and hang them on a series of hooks. Immediately before you two ladies in deep mourning are ascending the stairs, each with great branches or stems of white chrysanthemum from the hothouse of some Petrograd florist.

Their visit this Sunday is no longer to a living relative; but others also bring flowers, and have come to cheer the occupant of some bed in the lofty and well-appointed ward above. A waiting-room on the second floor is at length reached, and a sister or nurse will attend to the visitor. Bearded orderlies in white, with the red cross on their left arm, move across the room to the wards beyond, and through the open door you can see the active life of a hospital in full swing. A cheerful young fellow wheels himself in on his rubber-tyred chair, two crutches beside him being the only visible sign that he is quite unable to walk yet. My visit was to see my General, commanding a cavalry division at the front. Five weeks ago he was wounded in the right arm, which is yet in a sling, but what was that to a man like him at such a time. Others might return to Petrograd to be fêted and petted, but his place was in the field, and for three weeks he remained there. But one evil day the doctors pronounced that an operation was necessary, which could only be done at the base, as it would require rest and care for months afterwards. Accordingly he returned to the capital, determined to get another opinion, and put off the operation if possible. His wife and daughter met him, and on this very day the doctors were to give their final answer on his case. It was his hope that with a week's careful treatment he might return to the front, and he had promised to take me with him.

An orderly had taken my card and disappeared in the passages beyond; presently he returned with a sister. "Could I perhaps see the General, and how was he?" "He is at this moment under operation, and cannot see you for a week at least."

Words cannot quite paint what this meant to me. Such a chief, such a chance to go with him, to accompany a big cavalry raid, which I knew to be intended shortly! I had in my pocket a final list of what I had got and was to get, to be as little trouble as possible once we were off.

But in my heart of hearts there had been an unspoken feeling that for him, for his safety, no patch work was as good as getting to the root of the matter, even if it entailed an absence from his command for two months. The evil if not radically treated might well have got beyond cure at the front, and the doctor who sent him back no doubt knew this. At the same time so determined was he to return now if possible and put off the operation, that but three days before his daughter had told me that in no case would the operation be at once, but that to day we should know how soon he could safely start. There was nothing to be done but sit down and wait, watching others, until the good news came that the operation was safely over and the patient sleeping peacefully while his wife and daughter watched by his bedside.

Thanking the good nurse, an educated lady volunteering for the duty, but already with two months practise, quite professional in her manner, I went down the stairs, and giving the invariable small coin to the orderly I received my coat and hat, and was shown on my way very much at a loose end.

When I thought of the 5,000 beds already maintained by the Red Cross in Petrograd alone, I felt that there were those at home who might like to help a society, the needs of which were so much more extensive than ours, I am thankful to say, ever could be.

October 12th, 1914. S. L. NORRIS.

P.S.—Subscriptions may be sent the to Secretary, 917, Morka, Petrograd.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Intensive Treatment of Syphilis and Locomotor Ataxia by Aachen Methods By Reginald Hayes, M.R.C.S. (Baillière, Tindall & Cox.)

We welcome the appearance of this little book. The author pleads for a more general use of mercurial inunction in the treatment of syphilis, especially when the disease affects the nervous system. He compares the method briefly but fairly with the administration of the drug orally and by injections, and he fully admits the value of salvarsan when used in conjunction with mercury and iodides.

It is with cases of cerebro-spinal syphilis, including tabes and general paralysis of the insane, that the method seems of especial value when carried out efficiently, and with proper regard to the patient's condition. As yet it is too early to decide whether the direct intrathecal injections of salvarsanised serum or colloidal mercury will prove even more effectual, but the criticism often put forward that anti-syphilitic drugs, unless administered intrathecally, are unlikely to affect tabes or general paralysis, seeing that the choroid plexus does not secrete them into the cerebro-spinal fluid, would seem to be without justification. Tabes and general paralysis are, in the light of recent researches, the result of direct infection by the syphilitic organism of the tissues of the brain and spinal cord, and there would appear to be no reason why remedies given orally, by intra-muscular or intravenous injection, or by inunction should not reach these tissues in the ordinary way, viâ their blood vessels.

There is no doubt that syphilis is treated more efficiently now than ever before, but the treatment as carried out in general hospitals still leaves much to be desired. The oral administration of mercury and iodides, although advocated by such authorities as Sir Jonothan Hutchinson and Fournier, is by itself quite inadequate, and it is high time that every syphilitic, no matter what manifestation of the disease he may present, should be compelled in his own interests, and those of other people, to submit to the most thorough treatment possible. Syphilis is one of the few diseases over which we have some control, so that no sacrifice of money, time, or hospital beds can be too great in our attempt to ensure its complete eradication.

Every general hospital should have at least one large male and female ward devoted exclusively to syphilitics, where the mercurial inunction or injection method, combined with the judicious use of salvarsan, could be thoroughly carried out. Every case of secondary syphilis and all cases requiring vigorous and skilled treatment—such as syphilitic aortic disease and tabes—should, if possible, be admitted as In-patients, and all other cases should be forced to submit to a prolonged course of treatment as Out-patients by mercurial injections, iodides usually, and, when indicated, salvarsan intramuscularly. It should be pointed out that the internal use of sulphur, as an adjuvant to mercury, is of considerable importance, and forms an essential part of the Aachen methods.

There is another point. The fact that syphilis may cause disease of the lungs, gastric ulceration, and acute and chronic nephritis is not sufficiently recognised, at any rate in this country, and we would plead for a more extended use of Wassermann's reaction.

Cane Sugar and Heart Disease. By Arthur Goulston, M.D. (Baillière, Tindall & Cox.) 3s. 6d. net.

In this book Dr. Goulston describes the results he has obtained in treating heart disease by giving increasing doses of cane sugar. He begins by reviewing the evidence proving the importance of the role played by carbohydrates in the nourishment of the heart muscle, and goes on to point out that on this ground it is reasonable to suppose that in cases of myocardial weakness the condition may be improved by increasing the amount of cane sugar in the diet. After describing the method of giving it, and the precautions to be observed, he quotes some illustrative cases. In some of these the beneficial effect of the treatment seems to have been considerable, but in others the results are not so convincing. Unfortunately he lays undue stress on the form of radial tracings as indicating the improvement in character of the pulse. Anyone who has had much experience of the sphygmograph knows that the shape of a radial curve is determined far more by the exact position of the tambour and the pressure applied than by the force of the heart's contraction. The book, however, is of interest, and may induce physicians to try cane sugar in cardiac cases which do not react well to the ordinary methods of treatment.

Births.

CHASE.—On November 20th, at Sunnyside, Newbold Road, Chesterfield, the wife of R. Godwin Chase, M.B., B.C., B.A. Cantab, of a son.

DARKE.—On December 1st, at The Hollies, Harpenden, the wife of Sydney J. Darke, M.B., B.S., of 3, Pownall Gardens, Hounslow, of a son.

HIND.—On November 30th, at 2, Brook Street, Stoke-on-Trent, the wife of Guy R. Hind, M.B., B.S., of a daughter.

Deaths.

DONBAVOND.—On November 23rd, at Plymouth, after a severe operation, Edgar John Donbavond, L.R.C.P. Edin., M.R.C.S. Eng., in his 60th year.

HILLIARD.—On December 6th, Henry Charles Hilliard, M.D. Lond., of White Hill, Bletchingley, Surrey, in his 71st year.

JENNINGS.—On November 23rd, at Ramsgate, William Oscar Jennings, M.D. Paris, M.R.C.S. Eng., in his 63rd year.

W. E. T.